PADARE/ENKUNDLENI/MEN'S FORUM ON GENDER

MEN AS PARTNERS



Training of Trainers Manual

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2007

TABLE OF CONTENTS

MODULE VI: MEN AND COUNSELLING

Module VII: LEADERSHIP……..…..

Module VIII: COMMUNITY PARTICIPATORY…….……

LIST OF ABBREVIATIONS

AIDS Acquired Immune Deficiency Syndrome

CBO Community Based Organization

CHBC Community Home Based Care

GBV Gender Based Violence

HIV Human Immuno-defiency Virus

MSU Midlands State University

NGO Non-Governmental Organization

OVC Orphans and Vulnerable Children

SADC Southern Africa Development Coperation

STIs Sexually Transmitted Infections

TOT Training of Trainers

VCT Voluntary Counseling and Testing

ACKNOWLEDGEMENTS

The publishers of this training manual are committed to confront patriarchy and all forms of discrimination against women for a gender just society as well as the challenges that men and women are facing today especially in this era of HIV and AIDS pandemic.The aim is also to take men on board to start recognizing and realizing that women need to be complemented in their efforts at all levels and be treated accordingly in a more just and dignified manner when it comes to community development work and preventing gender based violence. There is need for men to start interrogating the weaknesses and gender injustices by other men through redefining manhood, challenging male power in sex and masculinity in the context of development work.

Preoccupation with masculinity and femininity needs to be superceded by that of humanity. As men and women, our needs and emotions are the same irrespective of status and class. Men need to be engaged sensitized and be motivated so that they can start engaging themselves in complimenting women's efforts in community activities including joining support groups, care work and also food security issues at a household and community level.

The impetus of this training manual was derived from the combined desire of Padare/Enkundleni/Men's Forum on Gender and its chapter membership in Zimbabwe to share experiences by preparing men to understand issues around fatherhood, redefining manhood, learning to be a responsible parent and also preventing gender based violence, the spread and impact of HIV and AIDS in Zimbabwe.

We would like to thank the University of Zimbabwe research team Department of Phsycology Mr Gwatirera Javangwe, Mr Kizito Mudzviti who helped in consolidating some of the important information on the research carried out in 2006 on Men's Knowledge, Attitudes, Beliefs and Practices and its interface with HIV and AIDS in Zimbabwe.Their contributions helped to strengthen the manual.

Special thanks go to the individuals who assisted in the production of this manual-Mr Jonah K Gokova (Chairpesron),Kelvin Hazangwi (Director), Eddington Mhonda (Programmes Coordinator), Rumbidzai Amin (Finance and Administration Officer), Charles Chigwada (Youth Coordinator),George Mike Jijita and Douglas Tigere (Intern students)

Many thanks and appreciation also goes to Tapiwa Manyati (Information and Knowledge Management Officer) for his creativity and innovation in developing this training manual and copy editing to its final stage. He approached this project with great care and a high level of professionalism.

INTRODUCTION TO THE MANUAL

Padare/Enkundleni/Men's Forum on Gender Men As Partners (MAP), Gender Training of Trainers Manual is for implementers and facilitators to be effective in sharing of messages on relationships, gender, gender based violence and HIV and AIDS issues.

The manual helps and emphasizes the need for sharing good practices as crucial to lessening bad male practices/social constructs of gender and impunity that has imprisoned women and children.

Background

In Zimbabwe, at least one in every three women has been beaten, coerced into sex or otherwise abused in her lifetime. Additionally, due to the political and economic problems besetting Zimbabwe, economic violence (for example denying women the chance to engage in both formal and informal work opportunities, failure to provide livelihood support and or withholding money often to the point of where a woman cannot feed herself or the children) is also thought to be widespread. The sheer magnitude of violence and its consequences justifies the need for greater investment in this area.

While both men and women experience violence, evidence suggests risk factors, patterns and consequences of violence against women more different than violence against men. As argued by Heise et l, “many cultures have beliefs, norms and social institutions that legitimize and therefore perpetuate violence against women”. Violence against women therefore cannot be separated from the norms, social structure and gender roles that influence women's vulnerability to violence. All too often such gender roles and expectations condone men's violence against women, grant men the power to initiate and dictate the terms of sex and make it extremely difficult for women to protect themselves from either violence or HIV infection.

Gender Based Violence is a pervasive public health and human rights problem throughout the world, but the patterns vary from place to place. The causes of domestic violence are a complex combination of cultural, legal, economic and political factors, yet it is a generally accepted view that gender based violence is the result of patriarchal ideology, values, norms, unbalanced power relations as well as strict divisions of labour, socialization processes and cultural customs and traditions. Poverty and low economic development further exacerbate the problem.

It is in men's interest to eliminate violence against women, prevent the spread and impact of HIV and AIDS. There is need to give special attention and recognition to people with disabilities in their vast capacities. They face discrimination and abuse on a daily basis. This is so because violence directly affects vulnerable groups in

societies whether as witnesses, relatives or survivors irrespective of gender, age, race, doctrine, creed or ethnicity.

Men need to be involved for them to be allies in efforts to eliminate violence against women due to the socialization processes that support them taking on dominant behaviours towards women that allow them to exert power and control over women, as well as enjoyment of privileges over women. Men also need to be involved and incorporated because only then will the message spread that men need to take responsibility for their actions, choose not to use violence and develop alternate forms of “masculinity”. This also calls male survivors of domestic violence to come out of the closet because of the socialization process and social constructs of gender that suppresses the feelings of men. Co-operation, partnership and dialogue between men and women must be fostered in order to create alternatives to prevent violence and foster environments that nurture peace and development.

Why this manual?

Evidence also suggests that, women have always been sidelined in leadership positions that involve decision-making. Where efforts have been put in place to ensure their participation in decision-making, most women lack confidence to actively participate and continue to assume subordinate roles. In addition, Southern Africa is the global epicenter of the AIDS epidemic, with the SADC countries being home to 38% of all the people in the world living with HIV. The epidemic is also “feminized”, as 59% of those living with HIV and AIDS are women. In the SADC region, young women in the 15 49 age groups are up to three times more likely to be infected by HIV than their male counterparts.

At household level, women are the managers of food, family and also carry the major burden of caring for patients on home based care and orphans. It is hoped that this manual will foster both men and women greater and effective participation in the decision making process around gender based violence so that it can better address some of the challenges they face in this regard. It is also hoped that as men better appreciate the burden carried by women due to the impact of HIV and AIDS, they will play a greater role in Home Based Care orphan care.

It is hoped that the Training Manual will help Padare/Enkundleni/Men's Forum on Gender create a greater long-term impact on the status of men in Zimbabwe.

Participants Targeted

The modules are designed to build TOT skills for trainers of Padare/Enkundleni and men to increase their knowledge base for the effective implementation of Men As Partners activities in working with men in Zimbabwe.

The focus of the training will be both awareness creation in gender, gender based violence and HIV and AIDS at the same time also developing skills and competencies for training community leaders and Community Action Teams (CATs). It is envisaged that the participants and partners will in turn be able to utilize these modules at grassroots level.

Teaching Methodology

Educating and training men about relationships, gender equality and equity or HIV and AIDS, redefining manhood, takes courage. The key to break perceptions of masculinity
and gender stereotyping, HIV and AIDS lies mostly with young boys and men. The first sight in this difficult process in through the promotion and facilitation of ideas into actions that will enhance an enabling environment so as to fight HIV and AIDS by participating in community activities including HBC through challenging social constructs of gender and deconstructing male power in sex. Culture and Masculinity as twined to sex by most young men. Boys and young men spend more time 'hanging out' leading to high risk behaviours.

The methodology in this training manual is based on engaging participants in very interactive exercises through education, co-facilitation skills, becoming good role models and sharing good practices based on the experiences and lessons learned. Lessons are drawn out from each session of the exercises.

To make this facilitation a success, there is need to overcome personal fears and discomforts about discussing and sharing knowledge and experiences on sexuality, STIs, HIV and AIDS issues. This will contribute towards creating and enabling environment that is free and friendly by engaging the participants.

Useful Steps when using this Manual

Read the whole manual.

A preliminary reading of the manual will give you a holistic view of what you will be teaching one another, an idea about the material you need to gather, and how you should prepare yourself to teach the course.

Create a no judgmental environment where participants' values are respected
Accept and respect all participant's comments and questions. Let them know that their concerns and opinions are valid and worthwhile.

Make participants feel comfortable

Avoid causing anyone potential embarrassments. Do not make participants answer a question they feel uncomfortable answering.

Conduct large group discussions

The more the participants are able to debate and talk with each other, the more they grow. After creating an atmosphere of openness and trust, you will still need to stimulate participation and involvement. Much of the manual will consist of involving participants in large group and small group interactive exercises.

Use small group discussions

Participants will take ownership of their work when working alone or in a small group. Small group work can also help to encourage men to speak up more, especially those who may by shy or reluctant to speak in larger groups.

Training design and plans

The main thematic areas of the manual and the time required to deliver each module are summarized in the table below.

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Module	**Module Title**	**Total Number of Hours**
1	Gender Concepts	2 hrs 30 Min
11	Redefining Masculinity	4 hrs 0 Min
111	Gender Based Violence	3 hrs 40 Min
IV	HIV and AIDS	2 hrs 30 Min
V	Male Involvement in Home Based Care	2 hrs 30 Min
VI	Men and Counseling	3 hrs 35 Min
VII	Leadership	3 hrs 20 Min
VIII	Community Participatory Decision - making	2 hrs 30 Min
	Reflection	45 Min
	Evaluation	45 Min
	Reference	-

Manual Implementation

The manual is designed to be highly interactive and emphasizes on participatory learning. Participants will be expected to learn from each other and collectively build commitment to implementing Men As Partners activities in Zimbabwe. This methodology has been based on the fact that the primary target audience will be youth- young men and men as adult learners. The information imparted and the activities used throughout this manual are to help those in training to do their work effectively and efficiently. Adult learners bring with them varying degrees of knowledge and understanding that must be recognized, drawn upon and discussed within the context of the training.

Facilitators Role

The facilitator's role is to set up a context in which learning can take place. The facilitator does not have to be a fountain of all knowledge. The information throughout the manual provides the facilitator with a good resource that is needed as a guide to the participatory process.

MODULE I

CONCEPTS OF GENDER

Materials: Flip Chart, Markers, Chalk board, Paper

Objectives (20 minutes)

The objective of the module is to enable participants to:

- Understand major causes of social inequity: place gender along with patriarchy and class.
- Understand the need for affirmative action and its role in bringing about equality.
- Analyze situations from the perspective of women.
- Be introduced to the concept of human rights.

Learning Objectives

The participants will be able to:

- Differentiate between equality and equity
- Understand the need for affirmative action and positive discrimination

CONCEPTS AND DEFINITIONS

Differences between Sex and gender (distribute Gender glossary)

Activity 1:

Step 1:Ask participants to be in pairs. Give a card to each pair containing a term from the glossary. Make sure that each term is given to two different pairs

Step 2: Ask each pair to write a definition on the card and WFP related example on the back of the card

Step 3: Ask each pair to read out their definition and compare this to the other pair that had the same card. Discuss the similarities and differences in definition.

Step 4: Give a handout on Gender glossary terms

Points to remember about Sex and Gender roles

Activity 2: Age Set Analysis (60 minutes)

GENDER ROLES	**SEX ROLES**
Masculine and feminine differences ? Socially constructed – different social and cultural codes of behaviour, role expectations, life-styles, power, influence etc. ? Vary over time. Since gender roles are socially constructed, they can be socially de-constructed. ? Determinants include; 1. Cultural beliefs 2. Religion 3. Political 4. Education 5. Peers	*Male and female differences* ? Biologically determined ? Uniform ? Universal and are shaped by the existence of different reproductive organs ? Unchangeable ? Given by birth

Step 1: Ask participants to explain how they make beer at their level.

Step 2: Involve participants in a simple gender analysis using the life cycle to determine the factors that are influential at the following different stages of the life.

Step 3: Divide participants in a simple gender analysis using the life cycle to determine the factors that are in influential at the following different stages of life.

0-5 years
6-12 years
13-18 years, 19-35 years
36 years and above

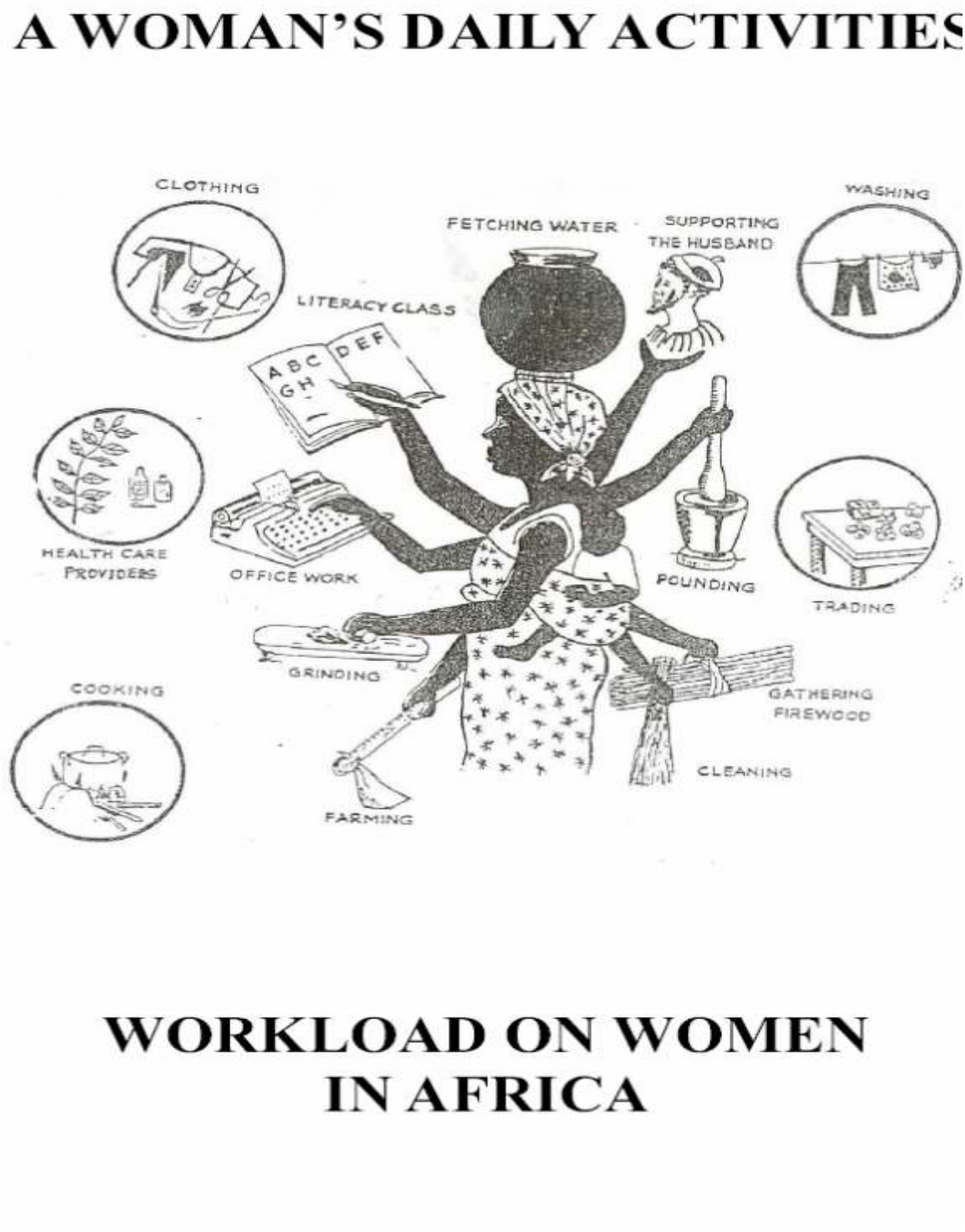
Expected answers include;

Age set	Influencing institutions	Gender differentials	Implications
0-5	- Media - Religion - Preschool - Peers - Community - Family	- Imitation of adults by gender - Toys and games - Preference by parents for one sex - Care takers and role models at pre-school are women - Social prestige of parent - Dressing pattern - Naming pattern	-Divorce result due to child preference - Naming -Frustration (satisfaction/dissatisfaction) - Learning ascribed roles - Reinforcing stereotypes - Career development - Social value differences - Self worth ratings - Nutrition & health care disparity
6-12	- Family - Media - Initiation - Peers - Community - School - Religion	- Images & messages in media - School enrolment rations - Workload sharing - Curriculum choices - Teachers and what they reinforce - Community expectations - Varied rewards and punishments - Sports & games (facilities) - Household chores - Family expectation and investment	- Absenteeism - Confidence building & esteem - Dropout - Positive and negative effects of media - Unwanted pregnancies - Unsafe motherhood - HIV/AIDS - Traditional careers for girls - Early marriages - Poor performance
13-18	- Religion - Family - Peer group - Community - Schools - Teachers M/F - Media	- School performance - Sexuality & how to handle it - Initiation into sex roles - Careers choices - Perception by society - Physiological changes	- Early marriages - Early pregnancies - School dropout - Boys delinquency behaviour - Self esteem and confidence - Workload versus time for study
19-35	- Tertiary instinct - Peers - Workplace - Family - Social clubs - Religion - Media - Community -Government policy	- Career stereotyping - Economic (in) security - Career opportunities - Further education - Domestication - Maternity versus paternity - Employment patterns - Marriages	- Unwanted pregnancies - Discrimination at work place (no promotions) - Men excelling in career women retarded - Marriage stipulates subservience for women - Child bearing add maternal responsibilities - Society pressure for conformity - Domestic violence
36 and above	- Family - Society - Religion - Workplace - Peer	- Roles well defined - Different advisory roles - Men in communal administration - Eldership - Strong association in clubs etc. - Pressure of parenthood - Consolidation in marriage - Polygamy	- Instability/ divorces - Respect - Improved economic status - Dependency begins on off spring - (Dis) inheritance of property - Marital stability

Step 3: Related the beer brewing example to the socialization process and how socialization process influence an individual's behaviour.

Comment:

Using the analogy of beer brewing, where, you need enough firewood, flour (chimera), sugar, time, water, wooden spoon for stirring in order to make the tasty beer. It is the same with men and women when they are growing up, they go through a lot of stages to be what they are and they are molded into what they are now.



Equality and Equity

Method

- Participants buzz in pairs to define equality and equity, noting the differences.
- In plenary they discuss their answers.
- What can be done to ensure equality, especially in the face of the multiple roles of women, which demand concentration on practical gender needs rather strategic needs:

CASE STUDY (30 minutes)

Gender Neutral Programmes at a Community level.

Participants to be presented the case study below:

A team of development workers conducting a needs assessment in a rural area in the south of Zimbabwe, consulted with the local elected and traditional leaders to establish the most pressing need in the area. They were told that the source of drinking water is a river that is about four kilometres away. The development workers also noticed that women spent many hours walking to the water source and carrying heavy loads of water back to the village. This confirmed what they had been told by the leadership.

After further consultations with the opinion leaders in the area, it was agreed that water was an urgent need. A project for the supply of water was designed and implemented quickly and eight months later there were six bore holes in the area, each one close to a cluster of homes. Women could access water within a few minutes walk of their houses.

The development workers returned after three months to monitor the water project. They found that all six bore holes were in a state of disrepair and none were being used as sources of water. Women continued to go to the river for drinking water, to wash clothes as well as bath.

Investigation into what had happened revealed that…

In groups complete the case study, indicating what the results of the investigation could have been.

The following points are some of the points would be raised:

a) The project of providing water was implemented without consulting women. This was like imposing aid on the community without consulting the beneficiaries.

b) Even ordinary men were not consulted, only opinion leaders and elected and traditional leaders were consulted.

c) The project used a top-down approach. It was not a resulted of the demands of the end-users.

d) The community was not given the skills to maintain the bore holes-no technical empowerment to enable the community to own the bore holes.

e) The triple roles of women do not allow them to be involved in borehole maintenance.

f) The project aimed at meeting only practical needs and did not consider the strategic gender needs of women that could have been met by meeting and socializing at the river.

g) The needs assessment asked people who were not the most direct beneficiaries.

h) Development workers did not use gender analysis tools in conducting the needs assessment

i) The project was not gender sensitive

Issues to be highlighted

a) There is a difference between EQUALITY AND EQUITY

b) Equality refers to the same treatment in dealings, quantities or values of outcomes. Treating everyone the same, regardless of outcomes. This can lead to serious inequalities, for groups that have been disadvantaged by a system that fails to take their situation and perspectives into account.

c) Equity refers to fairness which may require different treatment, or special measures, for some persons or groups. Substantive Equity, or Equity, is concerned with equality of outcomes.

d) Therefore special measures or affirmative action, or positive discrimination means to act, practice, program, plan, policy or some measure taken for the purpose of substantive equality e.g. women and men, indigenous people and dominant white people, minority religious groups and majority religious groups, people with disabilities and people without disabilities. The aim of a special measure is not to discriminate by conferring favours, but to achieve equal outcomes for people who have

encountered disadvantage in relation to those who have not.

SEXUAL AND GENDER DIVISION OF LABOUR (60 Minutes)

Activity 1: Role-play Materials: Cards

Step 1: Ask for 2 volunteers to do the role-play.

Step 2: Give instructions on how to do the role-play. Ask the other participants to listen attentively

Doctor : "Morning Sir, what is your problem?"

Mr. Mtengo : *"General body pains"*

Doctor : "What type of work do you do?"

Mr \Mtengo : *"I am a Farmer."*

Doctor : "How many children have you got?"

Mr Mtengo : *"God has not been kind enough, out of the 15 children that were born, only 9 are alive."*

Doctor : "Does your wife work?"

Mr Mtengo : *"No, she just stay at home."*

Doctor : "Oh! Fine. So what does your wife do everyday?"

Mr Mtengo : *"Aah! She wakes up 4am, goes to draw water, collects firewood, makes fire, makes breakfast then makes sure that everything at home is fine. Then, she goes to the river to wash clothes. Sometimes, once a week she goes to the mill. When she comes back, she goes to town with the two small children to sell tomatoes while knitting. This is along the road. Then she goes to buy necessities from the shop and goes home to make lunch."*

Doctor : "Do you go home at lunch time?"

Mr Mtengo : *"No, she brings the food to the garden, and this is 3 Kilometres from home"*

Doctor : "Then?"

Mr Mtengo : "She follows me in the garden weeding. After that she goes to attend to Vegetable garden"

Doctor : "What do you do then?"

Mr Mtengo : "I go to discuss important things and drink with my fellow village men."

Doctor : "Then"

Mr Mtengo : "I go home to eat supper prepared by my wife"

Doctor : "Does she go to sleep after supper?"

Mr Mtengo : "No, but I go to sleep. She has some other things to do at home until 9 to 10pm"

Doctor : "But you told me that your wife does not work?"

Mr Mtengo : "I said that! She does not work. I have told you that she just stay at home."

Source: Adapted and modified from The Oxford Gender Training Manual.

Step 3: Plenary and discussion.

Step 4: Link the role-play to sexual and gender division of labour.

Step 5: Distribute pictures; A woman's Daily Activities and picture of a relaxing man. Allow participants to comment on these pictures and make clarifications as necessary.

The sexual division of labour is based on the socially determined divisions of responsibilities for the reproductive and productive activities in society.

- Focus on societal role and responsibilities
- At home, community, national and workplace
- About power relations, dominance and subordination

Classification of Gender Roles

Gender roles are classified into;

- Reproductive (biologically determined)
- Productive.

- Community.

Reproductive: -

- Feminine activities.
- Home based.
- Invisible in national accounting statistics and records.
- Child bearing/rearing domestic labour, care of the elderly, the sick and community.

Productive activities

- Masculine activities
- In the public domain
- Waged work, recorded in national accounting statistics
- Higher status and economically valued

Community Activities;

- Done by both men and women
- In the interest of the community in general
- Developmental work

Gender Stereotyping

Gender Role Stereotyping	
Men shown as	***Women shown as***
Head of household	Housewife
Family protector	Goal keeper
Bread winner	Child minder
Independent	Dependent

Gender stereotyping is a common set of beliefs of the different roles and

responsibilities, values and attitudes and the abilities of women in relation to men.

Activity 2: Gender Stereotyping of Personal attributes (30 minutes)

Step 1: Read out the following traits and ask participants to decide whether

Female attributes	**Male attributes**
? Gentle ? Caring ? Less intellectual ? Physically weak ? Shy ? Risk averse ? Noisy ? Submissive ? Humble	? Rough ? Individualistic ? More intelligent ? Strong ? Courageous ? Risk taking ? Quiet ? Assertive ? Brave

they are dominantly male or female attributes/traits.

Expected answers include:

Step 2: Ask participants what they think of a man or a woman who does not have these attributes or does not fulfill this;

Usually, men and women who do not behave according to society's expectation or lack the above are degraded and humiliated as not being real men or women.

Now that you have established the difference between gender and sex, gender roles and sex roles; build on this knowledge to help participants understand how this leads to women occupying subordinate positions socially, politically and economically in every society.

Conclude the session by asking participants the following questions;

What are the economic differences between the roles assigned to men and women?
What is the social difference between the roles assigned to men and women?
Which of the above roles and responsibilities are associated with power
What are the implications of this in relation to food security?

Step 3: Ask the participants to draw a conclusion based on the knowledge gained

MODULE II

REDEFINING MASCULINITY

What is Masculinity?

Activity 1

Brainstorming (5 Minutes)

Ask the participants to brainstorm on masculinity

Notes to the facilitator

Masculinity is the culture-specific ideas, roles and behaviours that men are supposed to live up to in order to become accepted members of their own communities. Making men more aware of the costs of conventional forms of masculinity, both for themselves and for women and children, is an important step towards challenging gender inequalities. In all parts of the world, there are men who are aware of the straightjacket imposed upon them by traditional notions of masculinity, and who are more open to reassessing their roles and responsibilities.'

ATTRIBUTES OF MANHOOD

Activity 2:

What is a man? (30 minutes)

Materials: Paper, pens, markers, flip charts

Objectives: By the end of the module participants will be able to:-

1 Identify the attributes of manhood.
2 Explore the risky attributes of manhood.
3 Challenge the risky attributes of manhood.

Step 1: Divide participants in small groups

Step 2: Ask the participants to describe a true man and write their answers on a flip

chart paper

Step 3: The repertoire in each group should present to the whole group until all groups have finished.

Step 4: CATEGORISE THE RESPONSE

Step 5: Place each group's answers on the wall in the training room until the end of the training period

NB: Notes to the facilitator/trainer:

What is manhood?

From the responses of the PARTICIPANTS' perceptions of Manhood, five themes SHOULD BE established, and they are presented together with some of the major responses:

i) Biological

- Presence of male organs
- Has all/adequate/functional genitals (nhengo dzinoshanda/izito ezisebenzayo)
- Mature, above 25-30 years
- Sperms should sink in water, not float on the waters surface (fertility test)
- Physical strength
- Kuberekesa/ukuzalisa originator of a lineage

ii) Psychosocial

- Mental strength-can overcome constraints
- Does not cry (control or repression of appropriate emotions)
- Kushinga/ukuqinisela, fearless, resilient, determined-does not give up
- Macho/ machismo
- Dominance
- Pillar of strength

NB: There is need to challenge these stereotypes modes of thinking.Specifically to challenge men to promote the message that: “Men should treat women as equals not only at work, but also at home, in your personal lives”.

iii) Behavioural

- Final word in decision making(

- ❖ Be able to repair the iron, stove and change electrical bulbs

- ❖ Economic performance e.g. being able to fend for the family
- ❖ Aware of wife's problems and fends for step children
- ❖ One wife

At the personal level, for instance, it is important to be self-reflective in order to change violent attitudes and behaviour towards other people and to accept that other people are entitled to having different views from one's own

iv) Human Relations

- ❖ Leader
- ❖ Head of the family units
- ❖ Must not give an ear to what women/wife say and obey that
- ❖ Dominance
- ❖ Well behaved-cohabits well with others
- ❖ Respectable, socializes children well especially with their dres
- ❖ Well mannered, faithful too

NB: The facilitator should help participants that “real” men take responsibility for their families and see themselves as neither superior nor inferior to women.

v) Responsibilities, Care and Support

- ❖ Breadwinner
- ❖ Well behaved and cohabits well with others
- ❖ Should have mercy on wife
- ❖ Can do manly jobs e.g. repairing stove, iron, and bulbs
- ❖ Should help relatives that are in need
- ❖ Being able to fend for the family
- ❖ Aware of wife's problems and looks after step children

NB: At the family level, recommendations should emphasise the importance of building new loving relationships with partners and children, and learning to listen and be more democratic.

Activity 4:

ATTRIBUTES OF FATHERHOOD (30 minutes)

Materials: Paper, pens, markers, flip charts

Objectives: By the end of the module participants will be able to

1. Identify the attributes of fatherhood
2. Explore the risky attributes of fatherhood
3. Challenge the risky attributes of fatherhood

1. Divide participants in small groups
2. Ask the participants to answer the question when is a father a father?and write their answers on a flip chart paper.
3. The repertoire in each group should present to the whole group until all groups have finished.
4. Place each group's answers on the wall in the training room until the end of the training period

Notes to the facilitator:

Perceptions of fatherhood are categorised under six themes:-

i) Responsibilities

- Looks after the family
- Planning for the family even childless
- Who works, otherwise not a father if idle
- Disciplinarian, responsible
- “Sweats” at work also, not only in bed
- No “Small houses”
- Even with no property
- Clothes and teaches the children
- Who care for children even after impregnating (amitisa/uyamithisa)
- Accepts and is aware that children will misbehave
- Provides shelter and security
- Guardian

NB: It is important that we listen to the voices of fathers, recognize their own needs and interests, and make it clear how men themselves will benefit when they are actively engaged as fathers.

ii) Paternity

- A person who has a family but no children is not a father
- Plans for the upkeep of the family and even if childless
- Parent
- Man with a wife and child(ren)

iii) Sexual Behaviour

- Father in the bedroom (sexual partner)
- Sweats in the bed as well as at work
- One with no 'Small Houses'
- Man and father in one
- Satisfies wife/partner (anosya mukadzi asina nyota pabonde/osuthuisi umngakhe emacansini)

iv) Psychological

- In emotional control
- Thinks/reasons
- Not fearful, if so, then one is a child

v) Human Relations

- Musoro wemba/ (Head of the house/family)
- Rational, is not prone to emotional outbursts
- Loved but not feared by children
- Makes decisions
- Well mannered and behaved, otherwise "anonzi John"
- Family representative and custodian
- Has final word in decision making
- Provides and gives

NB: The inclusion of women in "male involvement" projects and discussions at work and at home is seen as essential to provide men with the opportunity to communicate directly with women on difficult reproductive health issues.

vi) Social/ Cultural

- Having and looking after a wife even if childless
- Aunt can be a father
- Elder brother
- Father's brother

Activity 5

(a) Brainstorming (30 Minutes)

Materials: Paper, pens, markers, flip charts

Objectives: By the end of the module participants will be able to

1. Identify the attributes of parenthood
2. Explore the risky attributes of parenthood
3. Challenge the risky attributes of parenthood

Step 1: Ask the participants to brainstorm on the meaning of parenthood.

Step 2: Ask the participants to define a parent or the question “what is a parent?”

Step 3: Record the answers given

Step 4: Ask the participants to explain how one becomes a parent or “when is a parent a parent?”

Step 5: Consolidate the answers

Step 6: Present additional views and link the answers provided by participants

Step 7: Link the answers to the perpetuation of masculinity and gender-based violence

Activity 5 (b)

Ask the participants to group / categorise the answers from activity 5(a) into the following categories, biological, social construction, responsibility, and socialisation

Notes for the Facilitator:

From the responses to perceptions of parenthood, four categories can be teased out, and they are presented below with some of their accompanying actual comments:

i) Biological,

- Father or mother who has given birth to a person
- Owner of the family
- Genetically responsible for the person
- Somebody capable of bearing a child
- Who has a child whether single or staying together
- Someone old enough

ii) Social construction,

- Muridzi wemhuri /umunikazi wemuli(Owner of the family)
- Superior role e.g. teacher

- Parents in the community

iii) Responsibility

- Owner of the family
- Is responsible and provides everything that is required by the children
- Women are parents because they are caregivers
- Grandfather(s), uncles (Sekuru's/ omalume/labokulu) can be a parent
- Inculcate social norms/values in children
- Does not influence children to terminate pregnancies (abort)
- Carrying children on the back by mothers
- Musara pavana/isigcini (surrogate parent)

iv) Socialisation

- Teaching/inculcating social values
- Elder person especially teacher

MODULE IV

GENDER BASED VIOLENCE (GBV)

Materials: Flip Chart, Markers, Chalk Board, Paper

Objective (20 minutes)

The objective of the module is to enable participants to:

- Understand Gender Based Violence, forms and the causes

What is Gender Based Violence?

Many people consider Gender Based Violence to be simply a man beating up his wife, or “wife-battering”, but it is not that simple. The best definition of GBV is a purposeful pattern of assaultive and coercive behaviours that adults or adolescents use against their intimate partners/ or co-workers or causing physical, economic, or psychological harm. Most gender-based violence is gender violence, which means it is violence by men directed at women or girls, due to the fact that they are female. Though males can be victims as well, we will refer to the abuser as male and the victim as female throughout the module as this is the most common scenario that you will encounter in counseling.

Forms of Gender Based Violence

Domestic violence is rarely a one-time event and usually escalates in frequency and severity. It is important to remember that domestic violence is not just physical, but can take many forms. The five main forms of domestic violence are:

1. Physical

- Punching; slapping; hitting; throwing objects; biting; pinching; kicking; pulling hair out; pushing; shoving; burning; strangling; raping; beating - often leading to permanent injuries and sometimes death
- Denying food, warmth or sleep
- Keeping someone locked up

- ❖ Keeping someone locked out of the house
- ❖ Refusing to help someone when they are sick, injured or pregnant
- ❖ Holding a person to keep them from leaving
- ❖ Abandoning someone in a dangerous place

2. Sexual

- ❖ Rape: using force, threats or intimidation to make someone perform sexual acts; having sex with a person who doesn't want to have sex; forcing sex after beating a person; forcing sex when someone is sick or when it is a danger to their health; forcing a person to have sex in front of others. There are three main categories of rape:

3. Power Rape:

The rapist uses enough physical force to subdue the victim. He uses each assault to prove that he is powerful and competent and to give him a sense of self-worth by deluding himself into thinking that the woman “wanted it” (most common form).

4. Anger Rape:

The rapist brutally beats and degrades his victim. He uses each assault to express his rage against women; usually these rapes are of women he knows. The pleasure he derives is not from the sex but from hurting and humiliating his victims.

5. Sadistic Rape:

The violence becomes eroticized. The victim is stalked and tortured (least common, usually carried out by mentally ill men).

- ❖ Sexual degradation, including: using abusive insults such as “whore” and “frigid”; sexual criticism; making demeaning gender based comments
- ❖ Forced sadomasochistic practices
- ❖ Insisting on unwanted and uncomfortable touching
- ❖ Forcing a person to strip
- ❖ Having affairs with other people after agreeing to a monogamous relationship
- ❖ Publicly showing sexual interest in other people
- ❖ Withholding sex and physical affection
- ❖ Minimizing someone's feelings about sex

3. Emotional

- ❖ Putting a person down: calling them “ugly,” “stupid,” “fat,” “worthless,” etc.
- ? Constant criticism
- ? Putting a person down in front of others
- ? Mocking
- ? Shouting
- ? Being excessively jealous
- ? Frequently accusing a person of flirting when they are not
- ? Controlling what a person wears
- ? Not listening or responding when someone is talking
- ? Refusing to accept a person's decisions, saying they have no choice in any decisions
- ? Lying to friends and relatives about someone
- ? Humiliating a person in public

4. Psychological

Isolation:from friends and relatives; monitoring or blocking a person's telephone calls or disconnecting the telephone; taking away their cell phones; telling someone where they can and cannot go; making someone a prisoner in their own home

Harassment: following a person; checking up on them; opening their mail, opening the mail boxes of their cell phones.

Threats: making angry gestures; using physical size to intimidate; wielding a knife or a gun; threatening to kill or harm someone, their children, their friends and family, or himself

Punishing or depriving the children when he is angry with their mother

Abusing the pets to hurt someone or their children

Denial: Saying the abuse doesn't happen; saying the abused caused the abusive behavior; being publicly gentle and patient or charming, but privately violent and abusive; crying and begging forgiveness; saying it will never happen again

Manipulating a person with lies and contradictions

5. Financial/Economic

Keeping a person from working

Controlling someone's money or the household/family money

Withholding money

Spending money on himself (often on alcohol or drugs) or/and on other women

MYTHS ABOUT GENDER BASED VIOLENCE

ACTIVITY: Presentation and discussion (30minutes)

Materials: Paper, pens, markers, flip charts

Objectives:

By the end of the presentation participants should be able to

1. Identify the myths about gender based violence
2. Explain how these myths fuel gender based violence
3. Suggest how these myths can be changed

The perpetuation of myths about gender based violence are dangerous not only because they encourage social acceptance and apathy towards the problem, but also because many women believe them which leads them to justify, minimize or deny the violence they are experiencing. This prevents the vital step of acknowledging that they are in a dangerous and violent situation, which is an essential step towards seeking help. Therefore, it is essential to dispel these myths both in the community at large and with individual counselees. The following are some of the most common myths that you will encounter:

1. “It's just the odd domestic tiff. All couples have them.”

It is true that all couples have disagreements at some point in their relationship. However, a relationship that involves violence amounts to more than a disagreement and is based on an imbalance of power and control. A relationship that is healthy, which includes the occasional verbal disagreement, is based on respect, trust, support and love for the other. Gender Based Violence involves constant or cyclic physical, sexual, emotional, psychological and financial abuse. There is no room for any such abuse in a healthy relationship. It is harmful and dangerous. In England and Wales between one and two women are killed by their partners every week - unfortunately there are no corresponding statistics for Zimbabwe.

2. “It can't be that bad or she'd leave.”

As listed previously, there are many, many reasons why a woman stays with her abuser. In Belize the practical hindrances to leaving an abuser are greater because there are not the same support services that are in place in most western countries.

3. “Domestic violence only happens in working class families”

Although it is argued that poverty exacerbates domestic violence, in the sense that a woman's options of other financial and practical support are very limited or non-existent, and that financial problems can place strain on a relationship, those involved in it and a family, it is not true that it is a problem specific to poorer families. Gender Based Violence cuts across all boundaries: economic (class), social, ethnic, cultural, religious and professional. Many women who have careers are abused and caught up in the same cycle of abuse as women who work at home. Factors of dependency and opportunity may differ but the psychological effect of abuse is the same.

4. “Abusers must come from violent backgrounds.”

Whilst there is a recognized pattern of abusers and abused continuing to abuse and be abused in their adult lives, it is not always the case. Many abusers do not come from violent backgrounds, and many families in which violence occurs do not produce violent men. The family is not the only formative influence on behavior. Furthermore, this statement is dangerous because it can be used as an excuse for the abuser's behavior, both by the abuser and the abused. The abused may be more likely to accept her abuser's behavior because she can rationalize it in this way, which in turn may lead to self-blame. This attitude also encourages the abuser to rationalize his behavior, prevents him from accepting responsibility for it and from seeking help to change it. Ultimately, adults are responsible for their own actions and have a choice in how they behave.

5. “All abusers are alcoholics or drug addicts, it's the drug that causes the violence.”

Alcohol or drug abuse is often mistakenly perceived as a cause of violence. An abuser may say that he lost control or didn't know what he was doing because of his alcoholism or drug abuse, but he is, nevertheless responsible for his actions. The drug may reduce the abuser's inhibitions, but his actions are his own, not the drug's. While substance abuse is related to violent behavior, successful treatment of that problem will not necessarily put an end to the violence. The abuser uses alcohol or drugs as one more excuse or justification for his actions, one more way to avoid taking responsibility for his own actions.

6. “She must ask for it/ deserves it/ provokes it.”

This attitude unfairly shifts the responsibility of abuse from the abuser to the abused. Many women who are abused over a prolonged period of time start to rationalize the abuse, this includes feeling she is to blame for it. Furthermore, if her abuser constantly tells her that she provoked the abuse, if social opinion accepts this excuse, and if he will not accept responsibility for his actions, then she is likely to

accept blame. Usually the battered wife will actually make extraordinary efforts to pacify their husbands. The abuser uses their abuse as a way to release tension and assume control; it is not a rational act.

The following is an exaggeration, but image if a robbery victim underwent the same sort of cross-examination a rape victim or a battered woman does. Would he report the crime?

--“Mr. Makufa, you were held up at gun point at the corner of First and Main?”
“Yes.”
--“Did you struggle with the robber?”
“No.”
--“Why not?”
“He was armed.”
--“How did you know that? Did he pull out a gun or a knife?”
“No, but he threatened to kill me.”
--“Then you made a conscious decision to comply with his demands rather than resist.”
“Yes, but...”
--“Did you scream? Cry out?”
“No, I was afraid.”
--“I see. Have you ever been held up before?”
“No.”
--“Have you ever given money away?”
“Yes, of course.”
--“And you did so willingly?”
“What are you getting at?”
--“Well, let's put it like this, Mr. Makufa. You've given money away in the past. In fact, you have quite a reputation for philanthropy. How can we be sure you weren't contriving to have your money taken away by force?”
“Listen, if I wanted to“
--“Never mind. What time did this hold-up take place?”
“About 11 pm.”
--“You were out on the street at 11 pm? Doing what?”
“Just walking. I had just come out of a bar where I'd been drinking with the defendant.”
--“Did you know the defendant before this evening?”
“No, I had just met him at the bar.”
--“Who paid for the drinks?”
“We each paid for one round.”
--“So you showed him that you were carrying a lot of money.”
“But, well, yes, butno, I didn't“
--“So you were just walking. You know it's dangerous to be out on the street that late. Weren't you aware that you could have been held up?”
“I hadn't thought about it.”

--“You hadn't thought about it? And what were you wearing?”
“Let's see... a suit. Yes, a suit.”
--“An expensive suit? A three-piece suit?”
“Well, yes, I'm a successful lawyer, you know.”
--“In other words, Mr. Makufa, you were walking around the streets late at night in a suit that practically advertised the fact that you might be a good target for some easy money, isn't that so? I mean, if we didn't know better, Mr. Makufa, we might even think that you were asking for this to happen, mightn't we?”

This is naturally a bit exaggerated and over-the-top, but it is the same convoluted logic that people use to blame battered women and rape victims for their own victimization.

7. “Batterers are just violent people, they're like that with everyone.”

Often the batterer is capable of being a delightful friend to others. He may have what is called a Jekyll and Hyde personalitymeaning someone who is nice during the day or on the exterior, and nasty and vicious at night, or inside his home. This is why friends of the family may find the stories of his violence unbelievable, and why they wife may deny the seriousness or the presence of the abuse as well. The truth is that the batterer chooses brutality as a way to dominate his wife.

8. “Women do not object to being mistreated.”

This idea stems from not understanding the helpless situation of a woman who has nowhere to run. The battered wife may have friends who will take her in for a week or two, but what will she do after that? Finding a job and paying rent while caring for children are daunting prospects. And the law may forbid running off with the children. Some women may even have tried to leave but were hunted down and taken back, either by force or by charm.

9. “Rape is just sex. It's not that big a deal.”

When dealing specifically with sexual violence, it is important to remember that men do not rape women because they can't find a willing sex partner, or because of a need for sex, they are using sex as a weapon. The following is a letter written by a survivor of rape to the Village Voice (a newspaper in Manhattan, NY, USA) in 1979.

This letter is a little graphic, but does provide a glimpse of how terrible rape is and what makes it different from sex...

Dear Editor,

I would like to offer a few comments on Molly Haskell's "Rape in the Movies: Update on an Ancient War" [Voice, Oct. 8]. As a rape victim, it seems to me that most people, male and female, even those who are sympathetic to the victim, do not fully understand the nature of forcible rape.
I believe that most view this crime as forced sex or intercourse, in the sense that this intercourse does not differ much in a physiological respect from that of consensual intercourse. Hence, "men seem incapable of understanding what rape means to women." Forcible rape is not in any normal sense intercourse. In most cases, the lubrication of the vagina required for normal intercourse does not exist, since petting has, more often than not, not occurred. As a result of this crucial aspect, as well as the fact that the victim is usually in a traumatized state immediately preceding the rape, and, thus, the muscles at the entrance to the vagina are not relaxed, penetration cannot either easily or immediately occur. What does happen is that the rapist repeatedly batters with his penis the very delicate and sensitive features lying outside the vagina, causing tissues to tear and bleed. When the force of the thrusting eventually results in the penis entering the vagina, it enters usually no more than a few inches, and again the tissues (this time the lining of the vagina) are repeatedly, with each thrust, ripped and torn.

As can be imagined, forcible rape is traumatically painful. I believe that it is the most physically painful ordeal that an individual can undergo and still live afterward. When I was being raped, I felt as though I were being repeatedly stabbed with a knife in one of the most sensitive areas of my body. Near the end, I was in shock. I felt numb and could feel no pain, but I knew the rapist was tearing me apart inside. Hours after the attack, the pain returned, and I felt as though I had been set on fire. Although I bled for only a few days, the pain lasted for weeks.

"What harm does it do?" Some of the flesh of my external genitalia has been battered away. It simply does not exist anymore. Other areas are torn and snagged. Some of my flesh can be pulled apart. Most of my hymen has been obliterated, with a ragged circular edge of tissue left in its place. Inside my vagina, the muscles at the entrance are damaged and I fear that this will adversely affect any future sexual intercourse that I engage in. Polyps have developed immediately before and at the entrance to my vagina. Also, the tissues of the lower part of my vaginal walls remain ripped. Thus, not only do people fail to comprehend the severe pain involved in a rape, or the length of time the victim must suffer, they also do not understand that the physical damage done on the genital organs does not repair itself with time and that rape is a mutilating, disfiguring crime.

Haskell states that "the integratedness with which a woman experiences love and sex and herself is what makes rape devastating," but this is not the whole truth, because there is no "sex" in rape. There is only pain traumatic, physical pain and I believe that this is what makes rape devastating.

Perhaps her theory best explains the rampant fear of rape as experienced by the majority of women who have never been raped, and who, therefore, do not anticipate having their vaginas ripped and torn for 15 minutes, but rather some sort of sex.

I have listened to many women say that it is probably better to submit to rape than to endanger one's life by resisting, all the while knowing in my heart that they had no idea as to the kind of hell they would be in for. I presumed they felt that they would be submitting to sex. I, myself, could not have imagined what rape really was like until it happened. I think that this confusion between sex and rape is largely responsible for the male fantasies of it as being pleasurable for the victim, for its glorification in the movies as such, and for the relatively light sentences imposed by judges on convicted rapists, as well as for Haskell's interpretation.

THE PSYCHOLOGY OF THE ABUSER

ACTIVITY:

Small groups

Step 1: Divide the participants into small groups
Step 2: Ask the participants to discuss the characteristics of abusers
Step 3: Each group reports until all groups are through
Step 4: The facilitator and the whole group revisit the characteristic of the abuser.

Materials: Flip Chart, Markers, Chalk Board, Chalk.

Objectives: By the end of the activity participants should be able to;

- Explain the meaning of an abuse
- Identify the characteristics of an abuser
- Link the characteristic of an abuser to the propensity for gender based violence

The following are some general characteristics of abusers:

- Anger, suspicion, moodiness, tension, resentment, hypersensitivity
- Helplessness, fear, inadequacy, insecurity
- Low self-esteem, loser mentality
- Exaggerated jealousy
- Inability to cope with being alone
- Jekyll & Hyde personality

- Projects blame and responsibility for his actions on partner and others, refuses accountability, downplays the seriousness of his own violence
- Drug or alcohol abuse (note: this does not cause violence, it only exacerbates it, see myth No.5)
- Believes in traditional gender roles and sex stereotypes
- Extremely controlling and possessive, often manufactures power struggles to prove virility
- Unable to handle stress (may be job related)
- Often charming and endearing to manipulate others
- Frequently uses sex as an act of aggression and to enhance self-esteem, believes in legitimized rape
- Feels victimized by partner and society, does not believe his violent acts should incur negative consequences for him
- Pushes for quick escalation of the relationship
- Unrealistically demanding ("If you love me...")
- Aims to be the center of the partner's world by isolating them from others and badgering them into letting go of the family and friends who would be a support network
- Blames uncontrollable urges and partner for his own violent tendencies and feelings
- Cruel to children and animals, frequently sadistic
- Verbally abusive, threatening, or degrading
- Comes from an abusive home, where he saw his father beat his mother

Abusive men may also have problems with communication or may find it natural to express themselves through violence because they experienced their parents "communicating" in this way (note: this upbringing still does not excuse the violence, see myth #4). When combined with poor anger-management skills, this leads to violence as the vehicle of expression. Anger generally follows a pattern that starts with self-need/ greed and leads to resentment that this need or greed is not fulfilled:

1. I'm not getting what I want
2. It must be someone else's fault
3. Someone else is wrong or bad for standing in my way
4. If I remove that obstacle then I'll get what I want

Resulting violence can release this anger and tension replacing it with the feelings of dominance and power that come from the satisfaction of getting their own way.

ACTIVITY:

THE PSYCHOLOGY OF THE ENVIRONMENT (25 minutes)

Materials: Flip Chart, Markers, Chalk Board, Chalk.

Step 1: Divide the participants into small groups
Step 2: Ask the participants to discuss the following question
Step 3: Ask each group to report on their responses
Step 4: The whole group then consolidate the answers

How does the environment in which men and women grow foster gender based violence and the submission of women?

Notes to the facilitator

There are many external factors that legitimate and facilitate the abuse of women and fuel machismo. Again, as with childhood upbringing, this is not to excuse the violence, or indicate that these are the only reasons, but only to show the relevant external pressures. Violent actions are always the choice and responsibility of the individual. External factors fall into six main categories:

1. Media/Entertainment: films and television programs provide male role models who use physical strength or weapons to solve problems or achieve goals. The media presents violence as exciting. Overwhelmingly the victims of such violence are women, especially in pornographic films. Manufacturers of goods, sports wear also use gender insensitive advertising to promote their products using machos views.

2. Societal/Cultural: the long-held concept of the ideal man has been the strong, silent type who fights his way to the top. Men are expected to be strong, aggressive, and in control, so boys learn at an early age to use force if necessary to gain and maintain control.

3. Historical/Religious: violence against women is also deeply rooted in our social institutions. Women have long been regarded as inferior to men; indeed for centuries they were considered the property of their husbands. Some religions continue to assert these beliefs today, though many deeply religious people have rejected such teachings.

4. Physical/Genetic: Men are genetically predisposed to be bigger and more muscular than women. Thus it is often easy for a man to force his wishes on a woman without fear of being physically injured himself.

5. Economic/Financial: men are traditionally better-educated and better paid than women. It is easy to dominate someone who is financially dependent and incapable of being self-sufficient.

6. Legal/Judicial: because virtually all domestic violence and many sexual assaults take place within the home, officials have traditionally been reluctant to enforce laws prohibiting male violence against women. While much progress has been made, far too many prosecutors and law enforcement officers continue to believe that “a man's home is his castle,” that if only the women were better wives their husbands wouldn't have to hit them. Likewise, criminal justice officials often ask a rape victim what she did to provoke her assailant, and marital rape has usually been seen as justifiable rather than assaultive. This minimizes the seriousness of the violent act.

7. Educational: The school socializes boys and girls in gender insensitive ways. The curriculum is designed to perpetuate gender disparities. Textbook publishers use gender-specific cover pages to textbooks which promote gender segregation. This instills male dominance.

THE PSYCHOLOGY OF THE VICTIM

ACTIVITY:

Small Group

Materials: Flip Chart, Markers, Chalk Board, Chalk. Paper, pens.

The first step that we can take in understanding the predicament of the domestic violence victim is to understand her psychological state. The following are characteristics often exhibited by victims of domestic violence and good warning flags to look for if you suspect that someone is being abused:

- Timidity, jumpiness, anxiousness
- Perfectionism, obedience, submissiveness
- Depression, despair
- Feelings of inadequacy, powerlessness, worthlessness, humiliation
- Sleeping disorders, eating disorders
- Suicidal, self-injury
- Truancy, withdrawal from activities and friends
- Crying easily, getting hysterical, overacting to minor incidents
- Low self-esteem

ACTIVITY: Presentation and discussion (15 minutes)

Materials: Flip Chart, Markers, Chalk Board, Chalk.

The facilitator should present the following cycle of violence to the participants. After the facilitator has presented, participants ask questions, while the facilitator clarifies on any issues that may arise from the presentation.

THE CYCLE OF VIOLENCE

Understanding the cyclic nature of an abusive relationship is helpful to understanding how someone can become caught up in a potentially never ending life of violence. Essentially, abusive relationships involve a build up of tension between two people, a violent explosion that releases the tension and things, and a temporary return to peaceful interaction. This cycle will continue and violence will become more frequent as the relationship progresses, unless the abuser makes changes to his behavior (which is unlikely to happen without professional help). The lengths of the cycle and of the three phases will vary from couple to couple. The following is a more detailed description of the phases of an abusive relationship.

Phase One; Tension Building

The abuser becomes increasing irritable, frustrated and unable to cope with everyday stresses. He is verbally abusive and there are some “minor” violent incidents.

The victim attempts to stay out of the abuser's way and do whatever she can to keep him calm - this is often referred to as walking on eggshells. She assumes responsibility for his anger and denies that the incidents get progressively worse.

Phase Two; Explosion/ Serious violence

The tension culminates into serious violence - this can be one incident or several.

While the woman may be able to recall the battering incident in detail, the man cannot.

It is unknown why the batterer stops the battering; he seems to know how to prolong the battering without killing his target.

In some relationships the woman is able to tell when the violence is likely to occur and can leave if she has a safe place to go.

The abuser feels a release of stress after he has been violent. This feeling becomes addictive and causes him to repeat the cycle when he is next under a lot of stress.

Phase Three; Honeymoon period

Some men are resourceful, loving and kind. He is usually afraid that his partner will leave him and so tries to convince her and himself that he will change.

Risk Factor	If she stays in the	If she leaves the relationship
Loss or damage to possessions	He may destroy things of importance or value to her to gain further control	He may destroy things of importance or value to her to gain further control, she may have to leave things behind when she leaves, he may get things in a
Loss of partner or relationship	He could leave her or be emotionally unavailable	Loss of partner and relationship
Being alone, single parenting	He could be emotionally unavailable, he could do little to help her with the children	He is unavailable and she may not be able to (or want to) find someone new, he may not visit or help raise the children, it may not be safe for the children or her to have him do so
Standard of living	He may control the money and give her little money to live on, he could lose or quit his job, he could make her	She may now live solely on her income, she may have to move out of her home or neighborhood, she may have less money
Loss of caretaker	If she is disabled and he is her caretaker he may not adequately care for her	If she is disabled and he is her caretaker he will no longer be there to help her
Substance abuse	She may abuse drugs and/or alcohol to help her cope with the emotional and physical pain	Even if she leaves, she will take an addiction with her, she may abuse drugs and/or alcohol to cope with her new life situation

Threat to "turn her in"	He may threaten this to keep her from leaving, he may force her to be involved in his criminal	He may threaten this or actually do it
Loss of residency	Ongoing threat, he could do it	Ongoing threat, he could do it
Loss of family / friends support	They may want her to leave and stop supporting her if she stays, they may not like him or may be afraid of him, he may keep her	They may not want her to leave him, they may blame her for the outcome and end of the relationship
Suicide (victim, partner)	He could commit murder suicide, she may commit suicide due to the psychological impact of surviving or desire to take control of a death she may	He could commit murder suicide, she may commit suicide due to the psychological impact of surviving or desire to take control of a death she may
HIV	Through unsafe behavior with her partner, she may have no choice regarding sex, he may sexually assault her	He may sexually assault her

The man plays dependent and falls apart without her, and she feels responsible for her victimization.

The woman finds it difficult to leave at this point because she wants to believe him and because this period of the cycle reminds her of the good times that they used to have, and that can be had.

In Zimbabwe, some women feel that violence from their partner shows that he loves her; this honeymoon phase could help explain why.

ACTIVITY: EMOTIONAL AFTER-EFFECTS OF GBV

Materials: Flip Chart, Markers, Chalk Board, Chalk.

Gender based violence, Domestic violence, like any other violent event can have tremendously damaging psychological consequences for the victim. The two most common syndromes are Post Traumatic Stress Disorder (PTSD) and Rape Trauma Syndrome (RTS). These are both very serious and anyone experiencing the corresponding symptoms should be monitored closely.

PTSD can occur at any point after the traumatic event, and can severely impair the victim's ability to cope with their situation. The criteria for diagnosing someone with PTSD are:

- Psychological reactivity to triggering cues
- Avoidance of triggering cues
- Intense psychological distress
- Dimming of responsiveness to others
- Change in attentiveness level
- Intrusive, persistent re-experiencing of trauma (i.e. dreams, flashbacks)
- Symptoms persisting for more than 1 month
- Symptoms cause significant distress or impairment in daily functioning

In an assault or a rape, events may seem to happen too fast, creating an overwhelming state of paralysis. This can produce RTS in the victim as she tries to cope with what has happened. This is manifested in both short-term and long-term symptoms.

Short-term (Acute) Symptoms (2 different styles exhibited)

1. Expressive

- Fear, anger, anxiety
- Sobbing, restlessness, smiling, tension, distress, inability to concentrate

2. Controlled

- Hidden or masked feelings
- Calm or subdued demeanor, withdrawal

Long-term (Chronic) Symptoms

- Life-style changes (residence, phone number, workplace, habits)
- Nightmares (reliving experience, exchanging roles with the abuser)
- Fears and Phobias (i.e. being alone, mistrust of men)
- Change in sexual activity (severe increase or decrease, sex can trigger flashbacks)
- Change in Relationships (decrease in trust of others, decrease in contact with friends and family, loss of confidence and self-esteem)

ACITIVITY: PHYSICAL AFTER-EFFECTS OF GBV (10 minutes)

Materials: Flip Chart, Markers, Chalk Board, Chalk.

Objectives

Step 1: Divide the participants into groups of 5 -7 people
Step 2: Brainstorming on the physical effects of Gender based violence
Step 3: Each group to decide on the types of physical effects of GBV
Step 4: The whole group deliberates on the possible physical effects of GBV

Notes to the Facilitator

- Serious injuries (i.e. broken bones, fractures, sprains, burns, cuts, concussions, lacerations, contusions, bites, perforated eardrums)
- Infections (anal, vaginal, pelvic)
- Dizziness, numbness
- Permanent disabilities (i.e. asthma, belly pain, muscle pain, irritable bowel syndrome)
- Miscarriages, unwanted pregnancies
- STDs, HIV/AIDS
- Death

ACTIVITY: THE PSYCHOLOGY OF THE CHILD

We know much about woman abuse. We know much about child abuse. But if we are to seriously address either one, we must recognize the links between these two forms of domestic violence. While one form of abuse can certainly occur without

the other, the tragic reality is that anytime a mother is abused by her husband/partner, her children may also be affected in both overt and subtle ways, such as:

- Seeing, hearing, and sensing the abuse
- Confusion, stress, and fear
- Feeling guilty that they can't protect her
- Feeling responsible, or that they are the reason she is being beaten
- Being abused or neglected themselves
- Headaches, ulcers, bedwetting, sleep disorders, abdominal pain
- Sons are more likely to abuse their future wives, and the daughters more likely to be abused by their future husbands
- Constant anxiety and stress about their mother's well-being
- Thumb-sucking, excessive clinginess
- Speech impediments
- Worry and uncertainty about their future
- Disinterestedness in their future, goals, or having self-control
- Embarrassment, reluctance to open up to or trust others
- Need to be invisible or perfect
- Suicidal thoughts or attempts, self-injury, depression
- Anger management problems, hostility
- Nightmares, insomnia, memory repression, denial
- Low empathy, low self-esteem
- Hyperactivity, constant attention seeking
- Withdrawal, truancy, running away from home

With traumatized children, one of the most effective ways of getting him or her to open up is having them draw what happened, how they were feeling before, during, and after the incident. This allows them to express their feelings without having to put them into words right away, which can seem overwhelming and scary. You can then use the drawings as a basis for discussion. It is important to allow the child to feel comfortable expressing their emotions in front of you.
If you think, for whatever reason, that you should refer the child to an outside agency or person, discuss this decision with the child, principal, and parent (if possible).

COPING WITH GENDER-BASED VIOLENCE
MENTAL PREPERATION

When someone experiences or lives with domestic violence there are also five main mental phases that they go through in coping with the abuse. It is necessary to move

through these phases in order to try to leave a domestic violence situation. These stages are:

1. Shock/Denial
2. Bargaining: Tries to talk to or reason with the abuser
3. Anger
4. Depression (and realization): Rage is turned inwards, in extreme cases it can result in suicide
5. Acceptance: This is the stage where the abused is able to take action (usually in the tension or explosion stage of the violence cycle).

It may take weeks, months, or years to reach the final stage. It may never be reached. In order to reach this stage it is sometimes necessary to hit rock bottom, to reach the point where you have to move somewhere and the only place is up. Even once the victim reaches this phase, she still needs to:

1. Seek emotional support and practical help
2. Make a crisis safety plan to help keep her and her children safe
3. Get advice about her legal rights and the appropriate procedures

It is extremely important to note that the victim must be the one to move herself through these phases. It is, of course, helpful and almost necessary to have someone they can trust to talk to and rely on for supporthowever this does not mean that you should take over the practical aspects of the process for the victim. Resist the tendency to treat her as a helpless child and do everything for her. For her to be able to successfully leave her abuser and rebuild her life she must be in control. This will help her to regain confidence in herself and her ability to be self-sufficient.

PRACTICAL CHECKLIST (IF YOU'RE STAYING IN AN ABUSIVE RELATIONSHIP)

Identify waning signs of abuse:

- ? Specific words and behaviors that precede a violent incident
- ? Specific actions or looks of your partner that inspire fear in you

Take actions before a violent incident to insure your protection:

- ? Create a list of emergency numbers and try to memorize it
- ? Figure out where you can go to be safe if you need to leave your house
- ? Decide if you can lie or withhold information to protect yourself
- ? Try to identify a friend or family member whom you can rely on for support
- ❖ Establish a “code word” or sign so that family, friends, teachers, or co-workers know when to call for help

? Think about what you can say to your partner if he becomes violent
? Teach your children how and when to dial the police and to stay out of any conflict between you and your partner
? Pack a bag with important things you'd need (money, keys, clothing,
❖ medication, records/documents, etc.) if you had to leave your home quickly

Assess your risks:

? What might happen to you (or your children) if you stay in the relationship?
? What might happen to you (or your children) if you end the relationship?

During an abusive incident:

? Stay away from the kitchen (the abuser can find weapons, like knives, there)
? Stay away from the bathroom or any other small space where the abuser could trap you
? Go to a room with a door or a window so that you can escape
? Go to a room with a phone so that you can call for help, locking the abuser outside if possible
? Call the police right away before the situation escalates

After an abusive incident:

? If a police officer comes, tell him or her what happened and get his or her name for your own records
? Document and take pictures of any injuries and seek medical attention

PRACTICAL CHECKLIST (IF YOU'RE LEAVING THE ABUSIVE SITUATION)

While you are gathering your courage to leave:

? Develop your job skills
? Start your own bank account
? Stay physically healthy
? Avoid pills, alcohol, and drugs as they will cloud your thinking
? Don't get pregnant
? Talk to someone you trust about the abuse
? Remind yourself that his behavior is not your responsibility
? If possible, ask his family to talk to him about his behavior

Once you have left the relationship:

? Change your phone number
❖ Save and document all contacts, messages, injuries or other incidents ?

- ❖ involving the abuser
- ? Change locks if the abuser has a key
- ? Avoid staying alone
- ? Plan how to get away if confronted by the abuser
- ? If you do plan to meet the abuser somewhere, do so in a public place
- ? Vary your usual routine
- ? Notify school/work contacts and/or family/neighbors of your situation if possible
- ? Warn your children to be careful and make sure they know to call the police and any other trusted adult if they feel that they are in any danger
- ? Talk to schools and childcare providers about who has permission to pick up the children from school or daycare
- ? Make your house as secure as possible
- ? Explore legal options to protect you and your children 105

MODULE V

HIV AND AIDS (1 hr 30 Minutes)

Objectives

By the end of the session participants should be able to:

- Understand why HIV and AIDS is a Gender issue.
- Explain the role of the community in preventing sexual exploitation and abuse.
- Explain the mode of transmission of and preventive measures for HIV.
- Explain the damaging impact of stigma and discrimination in HIV and AIDS
- Explore the link between HIV and AIDS, sexual exploitation and abuse.
- Explain the link between HIV and AIDS, gender and food security.

What is HIV and AIDS?

- AIDS, the Acquired Immune Deficiency Syndrome is a disease caused by the Human Immunodeficiency Virus (HIV)
- It weakens the immune system such that it can no longer fight off the infections as well as it could before. At this point many infections that would not normally be a problem become very dangerous.

What are Sexually Transmitted Infections (STIs)?

- These are diseases that are passed from one infected person to another during sexual intercourse. Examples include herpes, gonorrhoea and syphilis. HIV and AIDS is an example of an STI since one of its major forms of transmission is through sexual intercourse.

There is a close relationship between STI and HIV in the following ways;

- Mode of transmission is the same
- Mode of prevention is the same
- People with ulcerative STIs and those with frequent attacks are more likely to get infected with HIV
- STIs are difficult to treat in people living with HIV and AIDS

NOTE: Whilst STIs can be treated, AIDS cannot! Anti-retroviral (ARV) drugs are only able to help people living with HIV to manage it and leave longer and more productive lives by preventing or slowing some of the damage HIV causes.

Modes of HIV transmission

- Sexual through having unprotected sexual intercourse with an infected person
- Infected blood and blood products. For example, blood transfusions or sharing syringes or other drug injecting equipment with an infected person, or sharing a razor blade with an infected person in practices such as circumcision, female genital mutilation and incisions in traditional healing.
- Parent to child transmission when a baby is exposed to HIV while still in the womb of a mother living with HIV, during birth, or through breastfeeding.

Prevention of HIV and AIDS

- Abstain from sex
- Have one faithful partner
- Use condoms
- Avoid pregnancy if infected (unless if methods to prevent mother-to-child transmission are used)
- Stop sharing cutting or piercing instruments such as needles and razors blades
- Avoid having injections from untrained health personnel
- Avoid direct contact with blood and blood products
- Get counselling, and get tested for HIV regularly

Activity 1: Stigma and Discrimination (60 Minutes)

What is stigma and discrimination?

- Stigma; A mark or sign of disgrace or discredit; a distinguishing mark or characteristic
- Discrimination; Unfavourable treatment based on prejudice especially regarding race, colour or sex; a distinction made in the mind or in action.

Step 1: Arrange the chairs in a circle and place one card on each chair.

Step 2: Prepare as many cards as there are participants with one of the following roles written on each card. Ensure that there are at least two cards for each role;

A single man with AIDS
A single woman with two small children
An HIV positive pregnant woman
An elderly man with a little education
A young woman with little education

A widow
A woman with lots of sexual partners
A man with lots of sexual partners
A person with STI
A married man with no children
A married woman with no children
A single woman
A married man with two small children
A widow with two small children

Step 3: Ask participants to come in, ask them to take a seat in the circle. (Recommended group size 20. When the group is big split the group into two).

Step 4: Ask the group to form a line, shoulder to shoulder, facing an open area at least two metres deep. If there isn't room for twenty people to stand side by side in a line, split the group into two. One facilitator can work with one group while the other facilitator works with the other group or one group can perform the activity while the other group observes.

Step 5: Hand one card to each participant and privately tell them what their role is as written on their card. Tell participants including those who know how to read to keep their roles confidential

Step 6: Ask the participants to take one minute of silence to “get into their roles.” Tell them to think what it would be/feel like to be like that person.

Step 7: While still in their roles, ask the participants to take one large step forward each time they respond positively to one of the following questions: Say “take a step forward ---”

- If you can easily be registered in any community development project
- If you can live openly as you are, in any walk of your life.
- If you can use public transport easily
- If you can marry anyone you choose
- If you are respected by your religious institution/community
- If you can bring your partner to a TFD project function
- If you think Doctors will treat you with respect
- If you can rely on support from your family or community
- If are confident that you can participate in TFD and any community project successfully
- If you feel comfortable and secure to attend to project meetings in your area

Step 8: Advise participants to stay where they are. Ask the ones at the back to identify themselves. Ask what held them back. Ask how it feels to be in that position. Ask how they feel about those who moved forward. Ask the ones at the front to identify themselves. Ask how it feels to leave the others behind? Ask about how they feel about those who were left behind.

Step 9: Ask participants to sit down again. Ask them to try to distinguish between HIV and AIDS, “stigma” and “discrimination.”

Step 10: Ask participants to reflect for a minute on a time when they personally may have felt stigmatized, discriminated against or excluded from a group. Ask whether anyone would like to volunteer to talk about his or her experience.

Step 11: Consolidate the answers and present the definitions and additional views

Step 12: Ask participants to reflect privately for two minutes about whether they have biases, whether they have ever discriminated against or stigmatised a group or an individual and whether there was an impact of their actions or attitudes. Assure participants that they will not be asked to share these reflections. But as a facilitator encourage the spirit of openness.

Adapted and modified from WFP Stigma and Discrimination Module

If the following points do not come up, MAKE SURE to;

- Point out that we have all suffered from one form of stigma or discrimination at one time or another.
- Emphasize the damaging effects of stigmatization. Stigma affects the way people perceive themselves, and limits their potential. Internalising stigma impacts on people's dreams, relationships, how they work and on their confidence.
- As a result of stigmatization and discrimination, groups or individuals are excluded and marginalized both of which lead to destructive behaviour. With respect to HIV and AIDS, destructive behaviour can be deadly.

Link the discussion to gender and how destructive behaviour perpetuates the spread of HIV and AIDS.

Why is HIV and AIDS a Gender Issue?

Activity 1

Ask participants to brainstorm on why they think HIV and AIDS is a Gender issue.

The unequal power relations between men and women in our society make it difficult for women to ensure that they practice safer sex. Our social structures often put women in a position where they cannot say no to having unsafe sexual relations. Examples include; inability to negotiate sexual relations, rape, and gender based violence in married couples.

- The difference in power relations between men and women.
- Coerced sex.
- Negotiating safer and satisfying sex.
- Access to information and education.
- Higher levels of poverty among women.
- Stigma and discrimination around gender (male and female).
- Transmission from parent to child.
- The higher burden of care shouldered by women.
- Harmful traditional and cultural practices1 that compound the spread of HIV and AIDS.
- Men who know their HIV and AIDS status.

Men are socially taught to be household heads and therefore decision-makers. In sexual relations they initiate sex and women are supposed to be receivers.

A woman who requests for a condom or safer sex is considered promiscuous (immoral, sleeps around).

Biologically, the risk of women becoming infected with HIV during unprotected sex is 2 to 4 times higher than men. Women are also at greater risk of infection because of social, cultural and economic circumstances.

Gender Based Violence and HIV and AIDS

There is a close linkage between violence and HIV and AIDS that reinforces gender inequality.

- Violence increases women's vulnerability to HIV/AIDS and
- HIV and AIDS in turn may lead to violence against women who disclose their HIV status.

Additional views

There are a number of reasons why violence against women and HIV and AIDS overlap;

- Coercive sex can cause injuries and bleeding that can lead directly to an increased risk of HIV/infection for women. Usually in such cases, sex including rape is done without the use of condoms or other protective wear. Women are also unable to negotiate use of condoms in such cases.
- Abusive relationships represent an on-going threat to women again it is
- Difficult for women to negotiate condom usage and safer sex practices
- Within violent relationships.
- Women who know their HIV status or who are perceived to be living with
- HIV may be at risk of violence from partners.
- Studies have revealed that women who have been abused as children are more
- Likely to engage in high-risk sex practices e.g. multiple partners.

HIV and AIDS: Some Basic Facts

OBJECTIVES

By the end of the session participants should be able to:

- Understand what HIV/AIDS and STIs are.
- Explain the difference between HIV/AIDS and STIs.
- Explain the mode of transmission of and preventive measures for HIV.
- Explain the damaging impact of stigma and discrimination in HIV and AIDS.

What is HIV?

HIV stands for human immunodeficiency virus. This virus attacks the body's immune system, which protects the body against illness. HIV infects only humans.

What is AIDS?

AIDS stands for acquired immune deficiency syndrome. Becoming infected with HIV leads to a weakened immune system. This makes a person with who has HIV vulnerable to a group of illnesses that a healthy person who does not have HIV probably would not get.

What is the difference between HIV and AIDS?

A person infected with HIV may remain healthy for several years with no physical signs or symptoms of infection. A person with the virus but no symptoms is “HIV-infected” or “HIV positive”.

After a person has been infected with HIV for a period of time (often many years), symptoms caused by the virus begin to develop. At this stage, people with HIV are likely to develop opportunistic infections. “AIDS” is a clinical definition associated with HIV-infected people suffering from one or a number of specific infections, including TB, rare cancers, and eye, skin, and nervous system conditions.

Where does HIV come from?

Nobody knows were HIV came from, exactly how it works, or how to cure it. When AIDS first appeared in each country, people blamed AIDS on certain communities. Often, people think the fault lies with people from other “places” or those who look and behave “differently”. This leads to problems of blame and prejudice .It also means that many people believe that only people in those groups are at risk for HIV infection and that “it can't happen to me”. Confusion about where AIDS comes from and who it affects also makes many people willing to deny that it even exists.

How is HIV transmitted?

HIV is found in an infected person's blood (including menstrual blood), breast milk, semen, and vaginal fluids. HIV is transmitted in the following ways:

- ❖ During unprotected vaginal ,oral, or anal sex, HIV can pass from someone's infected blood semen ,or vaginal fluids directly into another person's blood stream, through the mucous membranes lining the inside of the vagina, mouth ,or rectum.

- ❖ HIV can be transmitted by HIV infected blood transfusions or contaminated injecting equipment or cutting instruments.

- ❖ HIV can be passed to a baby during pregnancy, delivery, and breast feeding about one third of all babies born to HIV- infected women become infected them. Unfortunately, it can take 12 to 18 months until it is known whether or not the child is infected.

Note: A breast-feeding mother who has HIV can pass the virus to her baby through her breast milk. Studies show that one third of babies who are breast-fed by HIV infected mothers will also become HIV-infected. However, breast-feeding is known to be beneficial to the overall healthy of the baby because the mother's milk is nutritious and protects the baby from disease. The alternative to breastfeeding for HIV infected women is formula feeding. This is not possible for most breastfeeding mothers because formula is too expensive. Even when formula is affordable, clean water is needed to mix with the formula and to wash the bottles used to feed the baby. Dirty water can cause the baby diarrhoea, which often leads to death. Clean water is a problem in many countries, and sometimes families may not have the fuel to build afire to boil the water to purify it. If formula and clean water are not

available it is probably better for HIV infected mothers to breastfeed. In these cases, the healthy benefits of breast milk probably outweigh the risk of HIV transmission to the baby.

HIV Myths and Facts

Objective

- To help the participants correctly identify factual information and misconceptions about HIV/AIDS.

Materials

Handout: “HIV: True or False” (pages--)

Steps

1. Review the list of statements provided on the handout “True or False'. Select specific statements from the handout to read aloud to the group. Ask the participants to indicate whether the statement is true or false and then to support their answers. Correct any misinformation by consulting the answer sheet provided in this manual.

2. Conclude the exercise by asking if the participants know of any other misconceptions about HIV that were not mentioned during the activity.

Training Options

You can begin the activity by having one participant at a time read aloud a statement and then have that participant and the large group respond.

- Another option is to divide the participants into four small groups and have them work together on the handout for 10 minutes before reviewing the answers.

HIV: True or False

Review each statement below, and decide whether you think it is true or false.

1. You can become infected with HIV from mosquito bites.
2. Anal sex is the riskiest form of sexual contact.
3. People can become infected with HIV if they perform oral sex on a man.
4. When used correctly, condoms can protect man and women from becoming infected with HIV.

5. Special medicines can cure HIV infection.
6. HIV is a disease that affects only sex workers and homosexuals.
7. If you stay with only one partner, you cannot become infected with HIV.
8. People with STIs are at higher risk for becoming HIV infected than people who do not have STIs.
9. South Africa has one of the highest rates of HIV in the world.
10. A man can transmit HIV to his partner during sex, even if he withdraws before ejaculation.
11. A man can be cured of HIV by having sex with a girl who is a virgin.
12. HIV is transmitted more easily during dry sex than wet sex.
13. You cannot contract aids by living in the same house with someone who is HIV positive.
14. You can always tell if a person has HIV by his or her appearance.
15. Sangomas can cure HIV.
16. HIV can be transmitted from one person to another when sharing needles during drug use.

Responses to HIV: True or False.

1. You can become infected with HIV from mosquito bites....False
   It has been extensively researched and proven that HIV cannot be transmitted this way. In Africa ,where malaria is common (and the spread from mosquito bites), the only people infected with HIV are sexually active men and women and babies born of HIV infected parents, and people and people become infected due to blood transfusions or sharing needles.

2. Anal sex is the riskiest form of sexual contact.....True.
   Anal sex caries a higher risk of HIV transmission than other types sexual contact During anal sex, the penis can tear the mucous membrane of the anus, which provides the virus with an entry point into the bloodstream Dry vaginal sex also cause tearing of the mucous membrane and, therefore, is high risk behaviour for HIV transmission as well.

3. People can become infected with HIV if they perform oral sex on a man.....True
   HIV is present on the semen of infected men. Therefore HIV may be transmitted if semen enters the person's mouth. A man can reduce the risk of transmitting HIV by wearing a condom and ensuring that no semen enters the person's mouth.

4. When used correctly, condoms can protect men and women from becoming infected with HIV.....True.
   Latex condoms are not 100% effective ,but after abstinence, they are the most effective way of preventing STIs, including HIV infection .Some groups

have reported inaccurate research that suggests that HIV can pass through latex condoms, but that is not true. In fact, standard tests show that water molecules, which are five times smaller than HIV molecules, cannot pass through latex condoms.

5. Special medicines can cure HIV infection .....False

Currently there is no cure or vaccine for HIV infection. Some drugs that can slow down the production of the virus in an infected person exists or prevent certain opportunistic I infections in an infected person, but they are expensive and difficult to access.

6. HIV is a disease that affects only sex workers and homosexuals.....False

Any one can become infected with HIV.A person` s risk for HIV is not related to the type of person he or she is, but rather the behaviour he or she engages in.

7. If you stay only with one partner you can not become infected with HIV.... False

Individuals who are faithful to their partner may still be at risk for HIV if their partner engages in sexual activity with other people. In addition individuals who are monogamous with their partner now may have contracted HIV from someone else in the past; therefore they may have the disease without knowing it and or without telling their current partner. Only along term monogamous relation ship with someone who has not been previously infected can be considered safe.

8. People with STIs are at higher risk of becoming HIV infected than people who do not have STIs ....TRUE.

Infections in the genital area provide HIV with an easy way to enter the bloodstream

9. South Africa has one of the highest rates of HIV in the world....TRUE

South Africa has one of the fastest growing AIDS epidemics. A UNAIDS report estimates that as of the end of 1999, 4.2 million people in South Africa were infected with HIV.

10. A man can transmit HIV to his partner during sex ,even if he withdraws before ejaculation.....TRUE

Withdrawal does not eliminate the risk of HIV infection. Pre-ejaculation fluid from the penis can contain the virus and can transmit it to another person. However, withdrawing is better than ejaculating inside the sexual partner since it minimizes the amount of exposure to semen.

11. A man can be cured of HIV by having sex with a girl who is a virgin.....FALSE

Some people believe this misconception, but it is not true. Virgins do not have any power to heal HIV infected peoples .There is no way to cure HIV once a person is infected.

12. HIV is transmitted more easily during dry sex than during wet sex....TRUE

HIV can be transmitted more easily during dry sex because of lack of lubrication causes cuts and tearing on the skin and mucous membranes of the genitals of both men and women .the cuts provide the virus with an easy way of entering the bloodstream.

13. You can not contract AIDS simply by living in the same house with someone who has the disease....TRUE

HIV is transmitted through exposure to infected blood and other infected bodily secretions. Living in the same house with someone who is infected with HIV does not put those in contact with him or her at risk unless they share items that have been exposed to the infected persons blood or genital secretions (e.g. through the use of shared toothbrushes, razors, or douching equipment.)

14. You can always tell if a person by HIV by his or her appearance....FALSE

Most people who become more infected with HIV do not show any signs of illness for years. However, the virus remains in their body and can be passed on to other people. People with HIV look ill only during the last stages of AIDS, when they are near death.

15. Sangomas can cure HIV....FALSE

Over the years many indigenous healers (Sangomas) have claimed to be able to cure AIDS .To the day, no treatments done by Sangomas have proven to cure HIV infection .we often hear of other people who say they have developed a cure for AIDS. People with HIV are a very vulnerable group because they desperately want to get rid of their life threatening illness and often will play large amounts for even a small chance of a cure. Many people see them as a source of easy money and try to exploit them .People with AIDS often feel better and seem to recover a little after taking useless treatments just because they have the hope of a longer life .Unfortunately ,there is no cure at the moment for HIV infection.

16. HIV can be transmitted from one person to another when they share needless while using drugs. ...TRUE

Sharing needles during injection drug use carries a very high risk of HIV transmission. Infected blood is easily passed from one person to another via

an infected needle or other equipment used to prepare or inject drugs.

Values about HIV and AIDS (30 Minutes)

Objective
To help the participants consider their beliefs and values about HIV and AIDS.

Time:45 minutes

Materials and Advance Preparation

- Four-forced choice signs (“Strongly Agree”, “Agree”, “Disagree” and “Strongly Disagree”)
- Markers
- Tape

1. In large letters print each of the following titles on the cards one title per card: “Strongly Agree”, “Agree”, “Disagree”, and “Strongly Disagree”.
2. Display the signs around the room, leaving them enough space to allow a group of participants to stand near each other.
3. Review the statements provide below, and choose ones that you think will generate the most discussion.

Steps

a. Explain to the participants that this activity is designed to give them a general understanding of their own and each other's values and attitudes about HIV and AIDS .Remind the participants that everyone has a right to his or her own opinion, and no response is right or wrong.

b. Read aloud the first statement you selected, and ask the participants to stand near the flipchart that most closely represents their opinion .after the participants have made their decisions, ask for one or two volunteers from each group to explain why they feel that way. Recognize that the participants may want to change their opinion during the course of the discussion and that the trainers should allow this to happen. The trainers can also encourage the participants to convince each other to change their opinion and come over to the other side .Repeat the process for each of the statements you selected.

c. After discussing all of the statements, facilitate a discussion by asking the following questions.

- Which statements, if any, did you find challenging to form an opinion about? Why?
- How did it feel to express an opinion that was different from that of the participants?
- For those of you who changed your opinion during the discussion, what made you change?

Note to the Facilitator

For the sake of discussion, if the participants express a unanimous opinion about any of the statements, play the role for the devils advocate by expressing an opinion that is different from theirs.

MODULE VI

MEN AND COUNSELLING

ACTIVITY 1 (20 minutes)

Counselling

Step 1: Distribute the following statements to participants in pairs.
Step 2: Ask the participants to indicate whether each statement describes counselling
Step 3: Ask the whole group to recap

Do the following describe counselling?

1. Counselling is a form of social conversation.
2. Counselling involves telling the client what to do.
3. Counselling involves a confidential dialogue between a person and a care provider aimed at enabling the client to cope with the stress and to take personal decisions.
4. Counselling involves a person-to-person interaction between the counsellor and the client during which the counsellor provides accurate information to enable the client to make an informed choice/decision about the course of action that is best for him/her.
5. Counselling involves a public brainstorming of the counsellor's or client's problem.

Notes to the Facilitator:

What is Counselling?

Allow participants to attempt to explain the meaning of the word “counselling”. Note the key points mentioned.

Lead the group to define counselling:

“a person-to-person interaction between the counsellor and the client during which the counsellor provides accurate information to enable the client to make an informed choice or decision about the course of action that is best for him or her”.HIV and AIDS counselling is a confidential dialogue between a person and a care provider aimed at enabling the client to cope with the stress and to take personal decisions relating to HIV and AIDS.

Three outcomes of the counselling process are:

i. counsellor helps the client define his/her feelings
Ii. counsellor provides unbiased information
Iii. client is empowered to make an informed decision/choice

Looking at the description of the counselling process above, as long as one understands the key points of the process ,i.e.

i. Counsellor must be able to provide accurate /current information about the topic being discussed.
Ii. There should be person-to-person on a one-to-one basis to assure confidentiality
Iii. Client, not the counsellor, must make the decision.

Let us now look at the definition below:

"Counselling is the process of assisting clients in making an informed choice/decision regarding how to change his/her behaviour."

Qualities of an Effective Counsellor

Duration: (1Hr 30 minutes)

TRAINER'S NOTE

Share the objectives of the session
Allow each participant to examine the words "principles", "practice" and review the definition of counselling
Lead the participants to define the terms as follows:
a) Principle guideline that governs a particular behaviour
b) Practice the process of doing something or performing an act or application of a known knowledge or something
c) Counselling the process of assisting clients in making an informed choice/decision about how to change his/her behaviour

Notes to the Facilitator: Qualities of an Effective Counsellor

A good counsellor is able to:
Establish rapport by meeting the client at his / her own level
Express empathy by being in tune with the client's feelings
Elicit needed information

Explore client's feelings
Give accurate information, without being judgemental
Give practical assistance, such as referral to appropriate services
Focus on circumstances, facts and feelings, which relate to the client's problem. As a result of the counselling interactions, the client emerges with increased self-confidence and ability to solve his/her problems
Accept the client as an individual
Encourage clients to talk freely about themselves
Help clients explore their feelings
Demonstrate respect and willingness to listen
Believe that clients can be helped to help themselves
Help clients believe that they have some control over their lives, i.e. they can make their own decisions and act on them
Evaluate the consequences of these decisions and the actions that follow
Adhere strictly to the concept of confidentiality, which must be made clear and understandable to the clients

SKILLS OF COMMUNICATION IN COUNSELLING

Objectives:

At the end of the session participants will be able to:
List the micro-skills of communication in counselling
Demonstrate the various skills needed for communication in counselling

Materials: Flipchart, stand, chalk/board, markers

Method: Role playing, demonstrations, brainstorming

Duration: 2 Hrs

Notes to the Facilitator:

Introduction:

Often we hear, but we aren't listening to the clients. Studies done on client or counsellor interaction show that counselors often interrupt the client many times during counselling exchange, cutting off critical information that the counsellor can use in assisting with decision making. This does not show respect for the client and does not allow the client to feel at ease.

Listed below are some of the listening skills needed by counsellors to be active and good listeners: It is very important for counsellors to:
Be attentive

Concentrate on the client
Summarize, reflect
Avoid interruption
Give non-verbal feedback (e.g. nod, smile, say “Mmmm”, lean forward)
Ask for clarification

Attending Skills

Body language: A counsellor should be able to read and understand the client's non-verbal body language. He/She should be able to differentiate between angry, happy, frightened or sad postures and looks. He/She should be able to interpret different gestures and facial expressions.

Eye contact: A counsellor should maintain appropriate and comfortable eye contact with the client.
The appropriate one is somewhere between an unwavering gaze (staring) and total aversion of the eyes.

Distance: The distance between the counsellor and the client should be close enough to indicate good rapport and acceptance.

Trunk lean/body movements, synchrony:
The trunk lean and the body movements of both the counsellor and the client should synchronize in such a way as to indicate understanding, closeness, and acceptance.

Quality of utterances:
It is equally important for the counsellor to take note of the quality of the client's utterances, in terms of the speed, the pitch, the volume, the quantity, and whether they are monotonous or varied.

Appearance:
It is also important for the counsellor to note the client's appearance, in terms of style of dressing, tidiness and cleanliness, whether the client looks rough or tidy, whether the clothes are decent or torn.

Encouragers:
These are simple but powerful forms of active listening closely related to body language. They consist of non-verbal signals and utterances given by the counsellor to encourage the client to speak or continue speaking. Such signals and utterances include nodding, Saying huunn, go on, oh, then, I see, okay, etc. These signals and utterances, if used unobtrusively, are indicators to the client that the counsellor is listening, interested and pleased that the client is expressing him/her self.

Reflections of facts, and feelings:
Reflecting back the meaning of what the client has expressed either with regard to

facts or feelings is a useful method of encouraging the client to continue talking. Sometimes this may be more effective than asking a direct question. It reinforces the idea that it is up to the client to engage in self-exploration, and that he/she should not depend entirely on the initiative of the counsellor.

Summarizing

Summarizing is similar to reflection in that it is feeding back what the client has said, but covers more. It is a useful skill to keep the client talking. It is also a useful way to close a topic and change the subject in the least disruptive way. Summarizing will include both reflections of facts and feelings. It avoids repetition and it is more concise than the client's statement. It must include the important points expressed and emphasized by the client. Summarising helps to give a clearer expression of the client's experience without moving beyond it into an interpretation.

Verbal following

This involves repeating what the client has said to indicate that the counsellor is paying attention to the client and to ensure that what he /she heard the client say is correct. This skill also allows the client to achieve self-exploration and understanding. It is useful in preventing direct questions from the counsellor.

Some issues that can arise during listening

When counsellor's response is not relevant to what has been said
When the counsellor changes the subject
When there is an incongruous response; when non-verbal messages appear to conflict with verbal messages
When the speaker is interrupted

Consequences on the clients

Makes them question whether they were heard
Causes them to question the worth of what they're saying
Causes them to lose confidence in the listener

The Art of Asking Questions

In counselling, questions are asked for the following reasons:
To know why the client has come
To help the client express needs and wants
To help the client express feelings and attitudes that allow the counsellor to know how the client feels
To help the client think clearly about choices
To show the client that the counsellor cares
To learn the client's knowledge of subject matter
To learn about situations affecting the client

How to question effectively

Use a tone that shows interest, concern and friendliness
Use words that the client understands
Ask one question at a time and wait with interest for the answer
Ask questions that encourage clients to express their needs, e.g.” May I ask you about your school and family?”
Use words such as 'then' “oh”. These words encourage clients to continue speaking
Avoid starting a question with 'why'; this suggests that one is finding fault
When asking a delicate question, explain why you are asking (e.g. when asking about the numbers of sexual partners
to find out about STI/HIV risk)
Ask the same question in other ways if the client has not understood

Expressive skills

These are verbal expressions that are used to help clients in self-exploration. They could be in the form of questions.

Questions

These are the primary tools that counsellors use to obtain information or seek clarifications from clients.
There are two types of questions: close-ended and open-ended

Close-ended questions

These demand short or one-word answers, e.g. How old are you? What is your name? Do you go to school? Are you married? They are very useful for obtaining demographic data and at the opening stages of the session. When overused they tend to lead to interrogation rather than counselling. Close-ended questions limit counselling sessions and put the
counsellor and the client in a difficult position to continue.

Open-ended questions

These demand long explanatory answers. They are the best to use in a session because they allow the client to talk more and also to come up with their own solutions. They facilitate more discussions. Examples are: Can you tell me more about your relationship with your sex partner? Could you explain that? How did that make you feel? How do you spend your leisure? Open-ended questions frequently start with the words What? Could? Would? How?
The difference between the two is the extent of freedom that the person responding has in choosing a response. Open-ended questions allow clients to exercise some control over the direction of the conversation while close-ended questions do not. In an open-ended question, the client can choose how to answer the question from a wide variety of responses.

Circular questions

These questions are used to identify patterns of interaction within the system. The questions also help the family to see how the whole family is involved in the problem and how family members influence and are influenced by the problem behaviour. Circular questions are used to link the past, present and the future in terms of behaviour and interactions. Circular questions are open-ended questions. Avoid "why" questions. When we use questions with children be careful about how the questions are phrased, taking into consideration the children's level of development.

Tense

This refers to whether the statement made by the counsellor is in the present, past or future tense. "'How are you feeling now?' reflects present tense. "'How did you react when your boyfriend told you what happened? reflects past tense. "Have you thought about how you will break the news to your wife/husband?" reflects future tense. The choice of tense reflects the emphasis of the discussion. The past tense is used to help the client explore how she came to have problems. The present tense focuses on what is happening in the counselling session. The future tense is used when the clients are beginning to think ahead as to how they will resolve their problem or difficulty.

Remember

Your motivation in asking the questions is: what do you need to know/ do you really need to know? Is the question necessary or might a reflection be better? What will you do with the information? How will the client perceive you? As interrogator, magistrate, policeman or helper?

Clarification/Reflections

A counsellor checks his/her understanding of what the client has said by seeking clarification, e.g. "Are you saying that.....?" "Did I get you right.....?" "Correct me if I am wrong...." Never make assumptions in counselling, always seek to clarify. If you are not sure of the meaning, check it out.

Activities

Practice sessions on demonstration of attending skills, encouragers, reflections, summarizing, verbal following, using close- and open-ended questions.

What is pre-test counselling?

Pre-test counselling: dialogue between the client and care provider aimed at discussing the HIV test and the possible implications of knowing one's serostatus leads to an informed decision to take or not take the test

should be offered to all who undergo testing
should be voluntary (it is against the rights of the individual to be tested without their consent)
should be devoid of coercion
Focus is on two main topics: (a) the person's personal history of risk behaviours or exposure to HIV (b) assessment of person's understanding of HIV/AIDS (mode of transmission) and how to cope in a crisis situation

Why is pre-test counselling necessary?

To review the client's risk of infection
To explain the test and clarify its meaning, to explain the limitations of the test results and caution about potential misuse of results (e.g. a negative result remains negative as long as no exposure to risk occurs) and to discuss preventive behaviour, risk reduction and condom use
To help the client think about possible reactions to the test result and who should be informed
To help the client understand why the test is required and to make a decision about the test

Steps to follow

Establish a good relationship between you and client
Identify yourself and clarify your role
State how much time is available for counselling
Emphasize confidentiality
Obtain client's particulars: name, age, sex, address, marital status, etc.
Establish what prompted the client to come for counselling and/or testing
Obtain medical history: blood transfusion, history of STI
Ascertain personal habits: drinking, smoking, condom use
Assess client's knowledge of HIV and AIDS, misconceptions, misunderstanding, etc.

Assessment of risk based on client's life

HIV and AIDS risk assessment requires discussion of personal sexual lifestyle of the client, with far-reaching implications. This entails assessment of:
Current and past sexual behaviour and relationship(s) of self and partner (e.g. one regular partner over many years, serial monogamy or multiple concurrent partners)
Use of condoms, practice of safer sex, frequency or unprotected vaginal, oral or anal intercourse
Sexual relations with multiple partner or known HIV-infected partners
High-risk behaviour, e.g. injecting drug use or commercial sex work (male or female)
History of previous blood transfusion or organ transplant
Exposure to possibly non-sterile invasive procedures, such as injections, tattooing and scarification

- Knowledge of the client about the test and its uses. Why the test is being requested.
- Clients beliefs and knowledge about HIV transmission and its relationship to risk behaviour
- Particular behaviours or symptoms that are of concern to the client
- Whether client has considered how he/she will react to the results of the test (positive or negative)
- If the test result is positive, who could be informed and who could provide emotional support

Remember that the client may not realize the reasons for the questions and may also be reluctant to answer questions about private matters.

Post assessment

After assessment of personal risk, HIV knowledge and coping ability:

- Correct myths and misinformation about HIV
- Review the test procedure, including issues related to false positive and false negative and also “window period”
- Explain and obtain informed consent
- Discuss potential implications (personal, medical, social, psychological and legal) of a negative or positive result; discuss and demonstrate condom use
- Establish a relationship of trust as a basis for post-test counselling

Activities

Pre-test Activity: Role Playing

Instructions:

- Read the situations below
- Ask the participants to be in groups of four. Each group will identify a counsellor, a client and two observers. The client will choose one of the case studies below as a model.

The counsellor will begin with an open question about the client's concerns, using some or all of the concepts previously learned.

Use the counselling skills that you find appropriate, including open-ended questioning, attending, paraphrasing, reflection of feelings, reframing, verbal following etc.

The observer will verify effective use of both skills and concepts in the counselling session.

After the counselling session, there will be time for feedback; the client will be the first to provide it, followed by the counsellor. The observers will be the last to give feedback to the counsellor. Once the role playing is completed and both the client and the counsellor have exchanged places, it will be the turn of the observers to play the role of counsellor to each other. All the participants will have to play the role of counsellors during the exercise.

Case Study One

Female sex worker, aged 32, married.

She has recently been diagnosed with gonorrhea.
She uses condoms occasionally with clients but never with husband .

Case Study Two

A 25 year-old bisexual male, married.
The wife is unaware of his occasional relationships with men.
He is currently involved with someone who is HIV-positive.
He doesn't feel comfortable talking about his bisexuality.

HIV and AIDS Post-test Counselling

What is post-test counselling?

Post-test counselling is aimed at discussing the HIV test result and providing appropriate information, support and referral and at encouraging risk-reduction behaviours.

What is the goal of post-test counselling?

The main goal is to help the client to understand and come to terms with his/her test results and to initiate adaptation to their seropositive or seronegative status.

Who should have post-test counselling?

All those who have undergone the test, regardless of the test findings

Fears about giving test results

Giving results (positive) can be difficult and uncomfortable
Counsellors fear they may not know what to say or do or may have an emotional reaction that may not be helpful to client; some fear that clients may harm themselves or others.
Counsellors worry that clients may leave the session and not return.

Activity

Write three fears about giving result.

Suggested steps for giving results

Begin the post-test session by asking how the client has been feeling since he/she had the blood drawn and congratulating client for returning or wanting to hear the test result; review your pre-test counselling discussions.
Ask if client has any questions, understanding that most clients will want to hear the test result as soon as possible.
When client is ready, give the test result in a neutral tone of voice, and wait for client to respond before proceeding.
For a positive test result, say: “Your test result was positive. That means you are infected with HIV”.
For a negative result, say: “Your result was negative. That means we did not detect

any antibodies for HIV".

It is important to ensure that client has understood the test result and absorbed the information.

Assess cognitive understanding by asking client to tell you what the test result means, checking for any misperceptions
and misinformation.

Assess emotional understanding by asking client how he/she is feeling at that moment, and allow for expressions of feelings.

Proceed to behavioural integration only when client is ready to talk about what he/she is planning to do next.

Behavioural integration requires that the client make an immediate plan, including partner notification, reducing risk and other behaviour changes, depending on the test result and the client's situation.

GIVING RESULTS OF HIV TESTING

HIV-negative test result

It signifies that HIV antibodies were not detected in the person's serum sample.

This result implies that the person is either not infected or that the person is still in the window period.

Clarify for the client that a negative result does not mean that the person is immune to HIV infection.

An HIV-negative person is still vulnerable to HIV infection if he/she engages in risk behaviour.

A person who tests negative but has practiced unsafe behaviour during the window period may be infected with HIV and infectious to others.

They need to continue to prevent exposure to HIV, maintain positive health behaviours, keep in mind the window period and protect themselves and others.

HIV-positive test result

With a positive result, it is important to inform the client as soon as possible.

A positive result means that HIV antibodies were detected in the person's serum sample.

The result means that the infected person can transmit the virus to others.

It does not necessarily mean that the person has AIDS.

Give the client time to absorb the news. Give a clear, factual explanation of what the result means. This is not the time to discuss progression of the disease or the estimated amount of time left to live.

It is the time to:

Explain difference between HIV and AIDS

Discuss positive living

Demonstrate appropriate condom use

Convey the need to seek medical health whenever necessary

Urge client to inform a trusted relation, spouse or friend

Refer client for follow-up where available, schedule appointment for partner(s) if possible establish relationship for future counselling

HIV-indeterminate test result

Presence or absence of HIV antibodies could not be confirmed.
This can mean that
The person may be in the process of sero-converting
The person may have a prior medical condition that is affecting the test , e.g.- arthritis or autoimmune problems
Explain the type of test used, the need for a retest, the need to prevent and avoid exposure to infection by ensuring safer sex practice or abstinence.
Provide psychosocial support during this period of uncertainty or appropriate referral if necessary and available.

Some possible reactions following positive test result

Shock
Denial
Anger
Suicidal thought or action
Fear
Sense of loss
Grief
Guilt
Depression
Anxiety
Loss of self-esteem
Hypochondria
Spiritual concerns

Determinants of reaction

How well-prepared the person was for the news
State of person's physical health
Type of support the person has in family, friends and community
How they learnt about the test result
The pre-test psychological condition of the person
Cultural and spiritual values attached to AIDS, illness and death.

What counsellors should bear mind in light of possible reactions

Pay attention to client's emotional reaction when they learn their result, especially if positive.
Be aware that, most of the time when clients learn that they are HIV-positive they may have these reactions: denial, followed by depression, anger and bargaining, and finally acceptance.

Recognize that learning to live with an HIV-positive diagnosis makes people highly sensitive.

Realize that multiple life stresses further complicate the psychological health of an individual.

Your role is crucial and you need to be supportive and helpful to enable the client to gain a sense of control over their overall health.

Post-test Activity: Role Playing

Instructions

Read the situations below:

Each group will identify a counsellor, a client, and two observers. The client will choose one of the case studies below as a model. The counsellor will choose to give a negative, positive or indeterminate result.

The counsellor must have in mind the proper protocols for each result.

The observers will verify effective use of the protocol and take home points.

Following the counselling sessions, there will be a brief time for feedback. The counsellor will be the first to express feelings, followed by the client. The observers will give feedback to the counsellor last.

Once the role playing is completed, the observers will take the place of the client and counsellor and be observed by the other two in the group.

All the participants should play the role of counsellor as well as give the result that they feel is most appropriate to practice on.

Case Study One

A woman, aged 25, married with four children. She says her husband refuses to use condoms, since he doesn't do anything outside the relationship. She knows that the husband cheats on her, even with members of her circle of friends.

Case Study Two

A 35 year- old white male, married with no children, since the wife is not ready to have children yet.

He sometimes frequents commercial sex workers.

The wife does not know about his husband's sexual escapades

The man thinks his wife is having an affair.

Case Study Three

A 17 year-old female student with lots of sexual partners.

She uses condoms at the beginning of the relationship, but stops as soon as she “knows and trusts” her partners.

She came here with flat mates who talked her into being “responsible”.

She could not sleep for a couple of nights, thinking about the test.

Other Types of Counselling

Crisis counselling

What is a crisis? It is an individual's response to a sudden change in personal affairs, for example:

- Diagnosis of HIV infection
- Unexpected death in family
- Breakup of a relationship
- Death of another PLWHA
- Emergence of new symptom
- Treatment failure or anything that an individual perceives as a severe life event

Crisis counselling is defined as a confidential dialogue between PLWHA and a counsellor aimed at enabling the client to cope with the crisis which is being experienced.

A crisis occurs whenever a client is:

- Intensely threatened
- Completely surprised and caught unaware by whatever is happening
- Emotionally disturbed as a result of loss of control and/or
- Emotionally paralysed because there seems to be no way to solve the problem

Note: any event that a person perceives and defines as a crisis is a crisis for the person

Characteristics of Crisis

- It is a subjective experience
- What one person perceives as a crisis may not be a crisis to another person
- It may manifest itself as an emotional reaction or disturbed behaviour such as deliberate self-harm
- It is hazardous and has the potential to cause psychosocial deterioration

A crisis situation is a critical situation in which a person is unable to use his/her normal problem solving techniques. The situation overwhelms the person emotionally and cognitively.

Role of the counsellor in a crisis

- Define the problem and restore a sense of control
- “Begin where the client is”
- Be reassuring and supportive as the client discusses the crisis
- Listen carefully; client may sound incoherent
- Comment on the strength of the feelings, the fear, or the client's efforts to deal with the problem
- Remain calm
- Accept the client's fear as genuine

It is the important that the counsellor NOT

- Play down the seriousness, for example by saying “you are over reacting”
- Panic

Offer false assurance
Give advice
Take offense

Elements of crisis

A crisis is made up of:

The blowthe shock of fearing or realizing that something is wrong, awareness of being at high risk, confirmation of HIV-positive status, death of self or loved one

The recoil-occurs when person struggles emotionally to come to grips with the full implications of the crisis

Withdrawalsome want to be alone with their sorrow or anger and to isolate themselves, others suffer depression or acute anxiety

Acceptancecoming through the crisis without permanent loss of self-esteem and with restored sense of control

Techniques used for crisis counselling

Use guided (structured) questioning, e.g., “We both need to know what is going on, so I am going to ask you some very direct questions”

Acceptance, e.g. “You may feel angry at yourself, at me, and everyone else. I accept those feelings”

Emotional support, e.g. “You may feel very frightened and you may need some extra time to talk. I am here for you.”

In using some of these techniques, counsellor should

Focus on the client's expression of current feeling and anxiety and affirm those feelings

Check whether the client shows decision-making ability, or gives an impression of helplessness and loss of control

Clarify what the client regards as the crisis and agree on a course of action to resolve or ease the crisis

Start to work on one aspect of the crisis that can be easily dealt with and build confidence in dealing with future problems

Repeat some information if the client is in denial or is too distressed to understand what is being said

Refer the client if there is need to do so

Guidelines in crisis counselling

Remain calm and show confidence
Listen actively
Show acceptance and be non-judgemental
Show empathy and reflection of feelings
Provide a relaxing atmosphere/an office
Allow client to speak freely, with minimal interruption
Allow ventilation of feelings
Explore immediate crisis rather than underlying causes

Assess suicide risk, ask the client about suicidal feelings
Do not minimize the crisis
Agree on a plan of action; do not prescribe
Prioritize; agree on aspects that can easily be dealt with
Have local resources to help; take all precautions necessary if there is definite risk of suicide

ACTIVITY FOR CRISIS COUNSELLING ROLE PLAYING

Instructions for Situations Below

Ask four volunteers who will work in pairs for each of the situations below. All others are observers.

Case Study One

18 year-old sewing apprentice diagnosed as HIV-positive six months ago.
Reports at counselling center in a state of shock.
Her friend, also HIV-positive, is now very slim as a result of prolonged diarrhoea.

Case Study Two

A 30 year- old single mother who has just been given a positive HIV result .

HIV prevention counseling

Prevention counselling is more or less similar to pre-test counselling as it provides an opportunity to the counsellor/client to negotiate and reinforce a plan to reduce or eliminate the risk of HIV transmission
Prevention counselling should:
Prepare the client to receive and manage his/her test result
Facilitate an accurate perception of HIV risk for those who are unaware, uninformed, or in denial
Translate the client's risk perception into risk reduction plan that may be enhanced by knowledge of HIV infection status
Helps clients initiate and sustain behaviour changes that reduce their risk of acquiring or transmitting HIV

What are the steps to follow?

Assure the client that test results and other information he/she provides will remain confidential
Discuss anonymous testing options
Provide client-centered counselling to:
Establish and/or improve the client's understanding of his/her HIV risk
Assess the clients readiness to adopt safer behaviours by identifying behaviour changes the client has already implemented and
Negotiate a realistic and incremental plan for reducing risk
Determine the client's understanding of HIV transmission and the meaning of HIV

Who in my children's life was affected?	How were they affected?	How can I be accountable or safe in future interactions?	Obstacles
Tanya	o Physically hurt o Scared for herself	Acknowledge violence was wrong, remains nonviolent in interactions with her	My belief that I have the right to use force to get my son back
Tim's friends	Lost their friend	Be nonviolent towards Tim	
Tanya's sister	Scared, angry	o Admit I was wrong	I want to see Tim
My parents	Sad, think it's Tanya's fault	o Take responsibility for my violent behavior o Tell them she was scared of me	Embarrassment, shame Afraid they will be angry at me

antibody test results
Remember that these will form the framework for post-test counselling and will strengthen the efforts the client has already taken towards healthier behaviour.

Bereavement counseling

People always experience grief upon learning that they or their partners or a friend is HIV-positive
Counsellor needs to understand grief and learn how to help clients through the different phases
Grief is multidimensional; it can be experienced on all levels of the person in the heart (feelings and emotions), the mind (thoughts), the spirit (meaning of life), the body (physical manifestations)
It is a time of transition, beginning with period of diagnosis to death, shock of an anticipated loss, of trying to “prepare”.
Grief refers to the personal experience of the loss; mourning refers to the process that occurs after the loss
Grief is a normal response to loss
For example, a couple undergoing divorce may mourn the loss of their relationship. People living with HIV may mourn the loss of good health.

Factors that influence how a person will respond to a loss

Who the person was and the nature of the attachment
Mode of death (natural, accidental, homicidal, etc.)
Where the death occurred (geographically near or far, sudden or expected, etc.)
Historical antecedents (previous losses and how the person grieved)
Prior mental history
Personality variables (age, gender, stress level, etc.)
Social variables (ethnic and social sub-cultures, religious persuasion and faith)
Degree of perceived emotional and social support
The secondary gain the person may find in grieving
Concurrent stresses, changes following a death

Five stages of mourning

Denial It can't be true
Anger- Why me?
Bargaining- Maybe if .....
Depression It's all over (past losses)
Acceptancea resignation, letting go, but memories still remain. Not always pleasant/happy
The stages are fluid, and an individual may move in and out of them in their unique individual manner and tempo.

Goals of grief counselling

To increase the reality of the loss
To help the person deal with spoken and unspoken feelings
To help the person overcome difficulties of readjustment after the loss
To encourage the person to say an appropriate goodbye and to feel comfortable reinvesting in life

How can counsellors deal with loss and bereavement?

Listen actively; your presence and desire to listen without judging or giving advice are critical helping tools
Be compassionate:
give client permission to express feelings without fear of criticism
allow them to experience the hurt, sorrow, resentment, anger, fear, anxiety or pain without expectations of what is “right”
Avoid clichés; words, particularly clichés, can be hurtful to clients (Clichés are trite comments that can seem to diminish a person's loss by providing simple solutions to difficult realities,
e.g. “You are holding up so well”, Time heals all wounds”, “Think of all you have to be thankful for”, etc.)
Keep in mind that your client's grief is unique
each person is unique and no one will respond to the death of a loved one in exactly the same way
there is no right way to grief
the process of grief takes a long time and each person has a unique time line for healing

Useful techniques for grief counselling

Use of symbols, e.g. photo
Writing and drawing
Use of ritual
Role playing and use of imagery
Memory book/memory box

Potential danger signals in grief reaction

When someone feels he/she is no longer of value as a person
Inconsistent behaviour or personality changes
When client makes threats of self-destruction
When clients exhibits anti-social behaviour
Excessive hostility
Complete withdrawal and unwillingness to interact with other people
Appearance of fleeing from reality

Session 1- SPECIAL COUNSELLING SITUATIONS

Objectives:

At the end of the session, participants will be able to:

- Identify the different types of situations for HIV/AIDS counselling
- Discuss the role of the counsellor in these situations
- Demonstrate the counselling skills used in these populations

PARTNER NOTIFICATION AND COUPLE COUNSELLING

What is partner notification?

Process whereby the sexual partner(s) of an infected client is notified, informed of their exposure to HIV/STD infection and thereafter offered counselling, testing and referral for support services.

Sharing and notifying partner(s) is very important for HIV/STD prevention, particularly in the longer term. It will help in achieving success in limiting the transmission, especially to women.

The aim is to:

- Provide counselling and testing to sexual partner(s) of client
- Provide psychosocial support to the partner(s)
- Provide referral and linkage to other support services, where available
- Observe the principles of confidentiality and trust
- Be non-coercive
- Be sure it is voluntary
- Be gender sensitive (studies reveal that disclosure rates are low and women fear abandonment or abuse if found to be seropositive)

Note: The health worker does not have a right to notify or inform the partner(s) of the client without informed consent. It is ethically wrong to do so. There is a need to observe human rights and respect the dignity of the client. The client should be counseled to understand the need and benefits of notification. Disclosure by health worker to the partner(s) without informed consent from client may lead to unprecedented situations and outcomes beyond the scope of the health worker.

Approaches to partner notification

Patient referral client is given the responsibility, after adequate health education and counselling, to inform sexual partner(s) of risk of infections personally

Accompany partner(s) to come for counselling, testing and provision of psychosocial support and referral

Provider referral

Client provides information to health worker to contact partner(s) and request them to come for treatment, usually more for STD cases.

Has a lot of problems associated with it, e.g. wrong names, addresses; it is labour-intensive, too expensive and not a sustainable practice, particularly in resource-

constrained settings.

Couple counselling

Counselling couples is a difficult (either spouse may not want to inform the other about their serostatus and if so, there is a possibility of transmission of infection)

There is fear of abuse, violence and abandonment.

Counselling an infected woman should take into consideration how she has learned of her condition.

Women often discover their infection by accidentusually after the husband/partner or child is already symptomatic with an HIV-infected disorder.

Counsellor should recognize that the woman will be dealing with at least two crises, that of her husband/partner's or child's illness and her own crisis.

Women's concerns regarding HIV infection are not only medical but also social and cultural.

Women are often wrongly accused of having brought HIV infection into their families, even if contradictory evidence exists.

Counsellor should acknowledge the woman's fear that her family and friends may abandon her because of her actual or perceived past behaviour, and should provide emotional support.

A woman's infection could be an indication of partner's infidelity (disclosure is usually traumatic, leading to loneliness and isolation, social stigmatisation).

Common emotional reactions are:

Angertowards the person who may have infected her

Griefloss of health and status, possibility of having to give up having children and of dying and leaving her children alone

Guiltfrom idea that she may have been the cause of illness in her own family, particularly her children

Infected women will be extremely concerned about the welfare of their children and may underestimate their own needs, or may even fear coming to clinics.

Linkages, referral and networking

Referral can be made to appropriate services where and if available.

Creating linkages, networking and referral is essential to ensure effective care across a continuum

Available resources within the community must be identified and linkage established with them for referral services

No single organization can meet all the identified needs of people living with HIV/AIDS and those affected by the disease (family members and orphans)

Resources available within the community could be formal or informal, e.g. government or NGOs/CBOs, social welfare systems, income generating schemes, women/youth groups, peer support groups of PLWHA

Conclusion

Coping and living with HIV and AIDS exerts a huge burden on the infected, the affected and the healthcare providers.
Increased awareness and understanding of the disease by community members will help reduce the stigma and improve support for people infected and affected by the disease. Community involvement and participation in social support, home-based care for infected persons and care of orphans will help ensure long-term sustainability of the services. Finally, the role of health workers as educators, care providers and role models is crucial in the success of prevention and care interventions. A lot of patience and empathy from all is required in the process.

Steps in Counseling

Counselling process proceed in four phases which are;

1) Defining relationship
2) Gathering information
3) Describing the problem
4) Making interventions

Activity

As group to role play a counselling session over a problem of a client who has been butchered by his wife. Ask a third person to listen to the interview and to make notes to indicate

a) whether or not the counsellor has moved through all the phases of the counselling (defining relationship, gathering information, describing the problem and planning intervention)

b) whether the counsellor has asked all the four questions necessary to the counselling process (current scenario, preferred scenario, goals and action).

1) Phase 1 Defining relationships

The counselor must clarify the counseling relationship in terms of its process and parameters. How counselors define themselves and the counseling context is crucially important for effective and ethical counseling. The counsellor defines the relationship usually in the first few minutes of counselling. The following points should be kept in mind when defining the relationship:
The counsellor should provide a context that is clearly therapeutic. Thus, establish a safe, confidential physical setting that distinguishes the counseling relationship from social conversations and.
Introduce yourself, the setting and the context. Do not assume that your client knows what counseling entails. Brief the client as to the objectives and procedures of counseling, and provide some idea of what is expected of the client, and what he or she may anticipate in return.
Allow the client to negotiate the definition of its relationship by listening observing

and confirming.
Be sensitive to how and what you communicate. Convey the critical message of trust (that you are trustworthy), acceptance (by being non-judgemental), and structure (that is you are skilled). Also assure the client that you will maintain absolute confidentiality.
De-pathologise the client's response to HIV serostatus and or gender-based violence, for instance if the client refers to his/her HIV status as a 'horrible affliction' refer to it as an 'HIV-positive status.'

2) Phase 2 Gathering information

Conversation with the client involve some form of inquiry. During the initial interview, the counsellor spends a considerable amount of time obtaining information about the client's current and preferred scenario so that both the counselor and the client can understand the problem and begin to think about planning possible intervention strategies. This phase is important because it represents the means by which the counselor constructs his or her understanding of the clients' world. How the counselor gathers the information determines how he or she understands the problem. The counselor should resist any attempt to give advice or to offer 'quick' solutions. Gathering information is determined by;
1) Supportive client-centred helping which means that the needs of the clients are central, and the ultimate purpose of the process is to identify and implement actions that will improve the client's situation (Egan, 1998). It is therefore important to allow the client to tell his or her story in his or her own way.
2) Active and benevolent curiosity relies on the counsellor's observation and questioning. By using active listening techniques and communication skills, the counselor tries to gain an accurate understanding of the client's problems, the way in which he or she is experienced these problems,. And what the client needs for a better future. The client should bear in mind the following points;
? Learn and adopt the client's language as a vital source of understanding and communicating empathy and acceptance.
? Use facilitative questions thus open ended not closed questions
? Be sensitive to feedback
? Be respectful
? Be patient and revisit topics if it is necessary to do so.
? Avoid suggesting solutions and prescriptions. Allow yourself time develop your understanding the client's world.
? Involve context in your inquiry.
? Focus on process over time. The counselor should attempt to understand patterns and trends rather than diagnostic entities (thus you do not only want to understand then the client is depressed, but also that also to understand that the client is depressed in terms of context and process).
? Thus the primary purpose of gathering information is to make the counselor an 'expert' on the clients' context and response to HIV/AIDS and or Gender-based violence. The counselor needs to listen attentively to what the client says. Drawing

premature conclusions about the client and his/her problems leaves the counselor with a limited understanding as the basis for subsequent phases.

3) Describing the problem dynamic

Once the counsello0r has gathered the information he/she needs to articulate his/her understanding of the problem dynamic on the basis of that information. The depth of the counselor on the basis of that information. The depth of the counselor's understanding will depend on the nature and comprehensiveness of the information gathering phase, which in turn will determine the efficacy of the interventions.
The first intervention that the counselor should make in the counselling process is to describe his or her understanding of the problem in its situational context. The counselor enters the counselling with a fairly restricted view of his or her problem. The focus of this phase is tom articulate aspects of the client's experiences in such a way that they are recognizable and confirming, but in a sense novel to the client. This phase focuses on facilitating self-exploration, clarifying feeling band describing the problem in such a way that interventions can be planned.

4) Phase 4 Intervention Action

Intervention is not a solution or action but a process in which the client becomes involved in order to improve the quality of his or her life. This is the phase in which the client answers the questions 'What do I have to do have to solve my problems?' and How do I make it happen?. In addition to providing supportive, client-centred counselling, the counsellor also acts as an active agent of change.
The aims of supportive client-centred stance is to give the client an opportunity to solve personal issues about his her HIV-positive status or traumatic gender-based violent experiences in a safe environment. This the focus in the intervention phase moves from the identification and description to setting goals which aimed at resolving the problem, deciding on methods of achieving them, and monitoring and evaluating.

5.6 Counseling Perpetrators of Gender-Based Violence

Perpetrators of Gender-Based violence inflict pain and fear on their families, and they also experience some negative consequences themselves for using violence.Think about what it is like to be a man who is doing many of the things on the Power and Control wheel. How would his use of violence affect his relationship with his wife or partner?
Ask participants to generate a list:

- Loss of trust from his partner.
- Loss of intimacy.
- Loss of respect.
- Loss of self-respect.
- Fear of getting caught.
- Possible arrest and jail-time if police are called.
- Possible loss of job and friends.

- Possible loss of partner and children.

How might his use of violence affect his relationship with his children?
Ask participants to generate list, including: His children

- are afraid of him
- run away when he tries to show them affection
- withhold information about their lives
- don't ask him for help or support
- don't talk freely with him
- aren't able to have fun with him because they are afraid of what he might do
- lie to him to protect themselves or their Mom
- use violence against him
- don't respect him

Activity: Tell the participants: Think of a situation where you felt controlled by another person or situation and you were unable to leave the situation (a job, your parents' house when you were little, a relationship, school or other institution, etc.). It should be a situation where the person had more power than you did. Answer these questions:

- What did the person or people do to control you?
- How did you feel? How did you think about the person or people who were controlling you?
- How did do you think the person controlling you felt towards you?
- What kept you from leaving the situation sooner than you did?

Accountability to Our Children - For Men Who Batter
Objectives:

1. To help men define responsible parenting
2. To look at the impact of GENDER-BASED VIOLENCE on children
3. To help men be accountable to their children and others for the violence

Lesson Plan

- Define responsible parenting
- Look at the impact of participants' violent behavior on their children
- Discuss ways to help children feel safer
- Complete an accountability exercise

Responsible Parenting
Tell Participants: Today we are going to talk about how each person defines responsible parenting. We will look at the impact of GENDER-BASED VIOLENCE on children and talk about what it means to be accountable to our children for the violence.
Ask Participants: What does it mean to be a responsible parent?
Generate a list on the board, including:

- Provide for children: shelter, food, clothing, education.
- Teach them positive values and skills for living.
- Teach them respect for others, including their mother.
- Understand their feelings and needs.
- Nurture them.

- Show them affection.

Ask Participants: What did you learn from your parents about being a responsible parent?

Tell Participants: Many men who have been violent to their children's Mom tell themselves that they have never hurt their children. But when a man is violent and abusive toward his children's Mom, he is also violent to his children.

Take some time to listen to the participants' reaction to this statement.

Ask for volunteers to share what they wrote. Think about any loud arguments or violence you saw or heard in your family when you were a kid.

- What did you see/hear?
- What did you do?
- How did you feel?
- How do you think this affected your relationship with your Dad or step-Dad?
- With your Mom?
- With your children's Mom?

Accountability to Our Children

Tell Participants: Let's talk about some ways we can lessen the impact of violence on our kids. The first step is to be accountable to our children, and all the people in our children's lives who may have been affected by our abusive behavior.

What is the definition of accountability?

- Being responsible for one's actions. Being able to answer for one's conduct and obligations.

Tell participants: Gender-Based Violence in a family can affect many other people who are connected with that family.

Have the participants listen to Roland's story and think about all the people in his son, Tim's, life who has been affected.

Roland's story

Roland and Tanya have been together for nine years. They have one son, Tim, who is seven. In their time together, Roland has hit, punched and threatened to kill Tanya. The last time Roland hit Tanya, seven-year-old Tim tried to stop him, and Roland pushed Tim out of his way. Tim fell and got bruises on his arms and legs and a scrape on his face. For Tanya, seeing Tim get hurt is too much. She leaves with Tim and goes to live with her sister in a different town. She files a No Contact Order (NCO) against Roland. Tim changes schools. He can't talk to any of his old friends because Tanya doesn't want Roland to find out where they live. She is afraid. Roland is very upset, and doesn't believe Tanya has the right to leave with their son. He calls Tim's school and asks Tim's favorite teacher where his son has gone. The teacher says he doesn't know, and Roland gets upset and hangs up on this teacher. Then Roland goes to Tanya's mother and pressures her to tell him where Tanya and Tim are living. Roland says, "Please tell me, I just want to see my son." Tanya's mother feels badly for him and tells him that Tanya is living with her sister. Roland goes to Tanya's sister's house. When the sister answers the door, Roland demands to see his son. The sister says that Tim isn't there, but Roland doesn't believe her. They get into an argument and Roland threatens Tanya's sister. In the meantime, Roland's parents

want to see their grandson. Roland says that Tanya has been "acting crazy" and has disappeared with Tim.

Let's think of all the people in Tim's life who are affected by Roland's use of violence:

- Tanya
- Tanya's mother
- Tanya's sister
- Tim's friends at school
- Tim's teacher
- Roland's parents

Let's look at how each person in Roland's life was affected, and what he can do to be accountable. Go over the grid below and fill in using Roland's story.

Table 2. Accountability

Adapted from Accountability in the Wilder Curriculum

Tell participants

Let's take some time to think through all the people who interact with our children and who may have been affected by our use of violence/abuse.

This can be a very difficult exercise, but as part of helping our children recover, it is important to think about each person who was affected and how they were affected.

Activity:

Think of four steps you can take to be accountable to your children. You can look back at Session 4 to review some of the messages we discussed.

Examples:

- Think about what we need to say to be accountable.
- Find a peaceful time to talk to our children.
- Acknowledge the specific violent behavior without rationalizing, blaming, etc.
- Tell our children that the behavior was wrong.
- Listen to our children's reaction, but do not demand a response.
- Be nonviolent in all future interactions with our children's Mom.
- Demonstrate to our children that we are safe to be around.
- Show them that we can be upset or angry without being scary.
- Speak positively to other family members about our children's Mom.
- Pay child support regularly (if applicable).

Think of some ways that your accountability can help your children.

Session 6: Parenting When You've Been a Survivor of GENDER-BASED VIOLENCE

Objectives:

1. To help mothers understand the impact of Gender-Based violence on themselves as parents
2. To help them to stop blaming themselves for the violence
3. To reestablish leadership with their children
4. To talk to their children about separation and visitation
5. To strengthen their support systems

Lesson Plan:

- Activity review
- Impact of GENDER-BASED VIOLENCE on Moms

- Establishing leadership with children
- Letting your child discuss their Dad at home
- Helping your child to feel comfortable with visitation
- Strengthening your support system

Activity Review

Ask participants: Did you go through the safety plan with your child? How did it go? Ask for a few examples.

Tell participants: We talked earlier about how GENDER-BASED VIOLENCE affects the abused person and the children. Now let's think about how GENDER-BASED VIOLENCE affects our parenting relationship with our kids.

Ask participants to think of ways GENDER-BASED VIOLENCE affects their role as a Father, both during and after the relationship with the battered spouses. Generate a list on the board. Examples could include:

- Overly permissive
- Overprotective of children at times when they don't need her protection
- Unable to pay enough attention to the children because she is overwhelmed by the violence
- Afraid of what will happen when children misbehave in front of Dad
- Rescues children from Dad's discipline/abuse
- Has difficulty maintaining structure or routines because of the violence
- Unable to contain anger at the batterer, and turns it on the kids
- Stress and fatigue leaves little energy for the children
- Abusing drugs/alcohol as a way to cope with the violence
- Gives children whatever they want because she feels guilty
- Afraid to discipline because the batterer has threatened to report her to CPS or sue her for custody of the children

Ask participants: How does GENDER-BASED VIOLENCE affect the way children act towards their Mom?

List responses on the board. Be sure to include:

- View their Mom the way the abuser labels her (stupid, crazy, etc.)
- View their Mom as weak because she "takes" Dad's abuse
- Don't respect Mom
- Don't listen to her
- Put her down
- Use power and control tactics against Mom
- Use physical violence against Mom
- Demand that she do what they want
- Treat her exactly the way the batterer does
- Try to take care of her all the time

Tell participants: GENDER-BASED VIOLENCE can affect a Mom in a lot of different ways. Lots of Moms who have been battered experience the following:

- Self-blame for the violence and its impact on their children

- Loss of respect from the children and loss of leadership with them
- Feelings towards the batterer that come out at the kids
- High levels of anxiety and stress in daily life
- Fear of leaving the batterer because of the impact on the children

Tell participants: Let's talk some more about each of these issues, and how to get past them.

Self-Blame

Tell participants:

Most men who batter blame their partners for the violence. When we are abused and isolated from our friends and family, we often start to believe the batterer, and think that he is right: It's something we did or said (or something we didn't do) that caused him to be violent. It's also very difficult to look at the man you live with or are married to, and the man who is the father of your children, and acknowledge to yourself that this person yells at you and hits you for no reason.

Many battered women who are Moms not only blame themselves for the violence, but also for the problems their children might be experiencing as a result. When a parent feels badly about their child's painful or difficult experiences, a normal reaction is to be easy on the children to make up for the hardship. In some situations, it is very appropriate to be easy on them; for example, when a child falls down and gets a cut and a bad bruise on her knee, most parents would not expect her to do her chores that afternoon. When a parent always feels badly or guilty about their child's experiences, permissive behavior becomes a pattern.

Now, I'm going to read a story about a Mom who finds it difficult to set limits with her son because she blames herself for the violence he witnessed.

Yolanda's Story

Yolanda and her husband Rafael have been together for 12 years. He has been physically and verbally abusive to her. Several times, he has pushed or slapped her in front of their son Zenzo, who is 10. She sees Zenzo getting into trouble in school and feels guilty about it. She feels that she is to blame for the problems in her family.

Yolanda is expecting a visit from her aunt and uncle in a half hour. Zenzo left several of his toys and some clothes on the living room floor. She asks him to pick up his things and put them in his room. He ignores her. She asks him again. He says, "You do it! That's your job. I'm busy. Why are you bothering me?" She wants to tell him to cooperate with her, but she thinks about all the things he's been through, and thinks she shouldn't start a fight. He goes out the door to play with a friend. Yolanda shakes her head and picks up the toys. Zenzo is talking to her exactly the way his Dad does.

How did Yolanda's feeling of responsibility for the violence affect her ability to set limits with Zenzo about cleaning up his stuff?

Why do you think that Zenzo is acting that way?

Ask participants: What might Zenzo learn from the fact that Yolanda didn't respond as a parent when he spoke disrespectfully, ignored her request to pick up his things, and walked out the door?

How would this interaction affect Yolanda's feelings for Zenzo?

Getting Rid of Self-Blame

Tell participants: Like Yolanda, many Moms who have been battered accept their children's abusive actions towards them, because they blame themselves for the violence. If we can get rid of this self-blame, we can do a better job of setting limits with our children, and have a better parenting relationship with them.
The first step is becoming aware of the self-blaming thoughts we have.
Ask participants: What are some examples of self-blaming thoughts?
List examples on the board, including:
- I should have left him sooner
- I should have just kept my mouth shut
- I shouldn't have upset him
- If I were a good Mom I would have stayed with him
- How could I have put my kids through that?
- My kids are hurt because of the violence and it's my fault

Ask participants: What are the feelings you have when you blame yourself?
List examples on the board, including:
- Guilty
- Hopeless
- Inadequate

Ask participants: What are some more positive or realistic thoughts that you could say to yourself instead?
List examples on the board, including:
- I did the best I could at the time.
- The violence was never my fault.
- My husband/partner is responsible for his own behavior and there's nothing I can do or could have done to change it.
- My kids are hurt because of the violence, but I did everything I could to protect them.

Ask participants for more examples.

Self-Blame: How it Can Affect Parenting

Tell participants that we will be doing this exercise for Activity. Review it briefly, using Yolanda's story as an example.
Think of a situation where you were overly permissive with your child because you blamed yourself for the violence.
1. Briefly describe the situation. I was expecting my family to visit. My son Zenzo left a mess in the living room. I asked him to pick it up, and he told me not to bother him and went out the door.
2. What were the self-blaming or negative thoughts you had? If I'd left his Dad when I should have, he wouldn't be acting like this. I don't know what to do with that boy.
3. What were your feelings? Helpless, hopeless, powerless as a mom, guilty for the violence.
4. How did these thoughts and feelings affect your behavior with your child? I felt there was no point in arguing. I didn't want to be hard on him, so I just let him go.
5. What are some more positive or realistic thoughts you could say to yourself?

About the violence: I left his Dad when I was able to. About your rights to set limits with your child: I have the right to expect him to cooperate, and to be responsible for picking up after himself.
6. What limits would you have wanted to set with your child? To speak to me respectfully, and to pick up after himself before he goes out.

RESOURCES FOR GBV SURVIVORS

CASE STUDY 1 (20 MINUTES)

Seeking help from a neighbour
Participants should be presented with the following case study.

You are watching a TV programme at home. You suddenly hear the cries of a distressed woman, calling for help, at the gate of your house. You go out to investigate. As you reach the gate, the survivor/survivor, Jane gives you an account of what happened. Both she and her husband, Denis are 33 years of age. They have been married for 10 years. Denis her husband arrived home early from night duty at a local hospital, to discover Jane in bed with a lover, who quickly escaped. This is followed by a heated argument between husband and wife, and Denis proceeded to hit her with fists. She tells you that Denis has been physically violent with her on several occasions. She has multiple injuries on her face and is bleeding profusely.

Participants should answer the following questions
1 What is your first reaction to the story?
2 Why do you think many women suffer from this type of violence?
3 List the many rights of infringed in this story?
Why is this type of violence not seen in the same light as an assault in the community?
4 Do you think that women's rights do not appear as important as men's? Comment
5 What preventive measures could be taken in this type of violence? By (a) the woman (b) the man (c) the extended family (d) the legal system
6. What does your church say about this type of scenario?
7 What steps can you and your group, take to ensure that you or those close to you will not have to experience/ cause such violence?

Ask the participants to in groups to complete the case study by, indicating what the results of the investigations could have been.

Participants share their responses with the group

CASE STUDY 2 (20 MINUTES)

Seeking help from a bystander and from a police officer
Participants should be presented with the following case study.

You at a police station reporting burglary that happened last night at your house. You suddenly hear the cries of a distressed woman, calling for help, at the gate of police station. Nobody goes out to investigate. You see a man coming wielding a knobkerrie. As she enters the reception of the police station, no one is within vicinity. The woman clings to you. The man threatens to kill both of you. Suddenly a woman police officer comes in and intervenes, the survivor/survivor, Rudo gives an account of what happened. Both she and her husband, Munashe are teachers at a local school where they have taught for 5 years. They have been married for 10 years. Munashe her husband arrived has not been coming back home of late. The wife followed after some tip offs. She has recently discovered that Munashe is dating and lodging with a form four pupil from the neighbouring school. This is followed by a heated argument between husband and wife, and Munashe proceeded to hit her with fists. She tells the police woman that he has been physically violent with her on several occasions. She has multiple injuries on her face and is bleeding profusely.

Participants should answer the following questions
1 What is your first reaction to the story?
2 Why do you think many women suffer from this type of violence?
3 List the many rights of infringed in this story?
Why is this type of violence not seen in the same light as an assault in the community?
4 Do you think that women's rights do not appear as important as men's? Comment
5 What preventive measures could be taken in this type of violence? By (a) the woman (b) the man (c) the extended family (d) the legal system
6. What does your church say about this type of scenario?
7 What steps can you and your group take to ensure that you or those close to you will not have to experience/ cause such violence?

Ask the participants to in groups to complete the case study by, indicating what the results of the investigations could have been.
Participants share their responses with the group

ACTIVITY1: Group work (20 minutes)

Step 1: Divide the participants into groups of 5 -7 people each and ask each group to list the possible sources of help for survivors of GBV.
Step 2: Plenary

Step 3: Let each group present their answers.
Step 4: With the help of the whole group

ACTIVITY 2: Role plays (15 minutes)

Step 1: Arrange the participants into a round-table so that every body will see the role play.
Step 2: Ask any two volunteers to come in front of the whole group and role play how a survivor of GBV can seek medical assistance and the possible obstacles likely to be encountered.
Step 3: Ask the help seeking participants how they felt and the help-giving participant how they felt acting that way and how they feel now'
Step 4: Ask the whole group to comment

RESOURCES FOR GBV PERPETRATORS

ACTIVITY 1: Group work (20 minutes)
Step 1: Divide the participants into groups of 5 -7 people each and ask each group to list the possible sources of help for perpetrators of GBV.
Step 2: Plenary
Step 3: Let each group present their answers.
Step 4: With the help of the whole group

PHONE NUMBERS/ADDRESSES:

ACTIVITY (15 minutes)

Step 1: Divide participants into small groups.
Step 2: Ask the participants to list all the possible sources of help for survivors and perpetrators of GBV.
An inventory of Organisations and individuals who can offer support should be drawn (the list should be relevant to the local needs of the participants).

NOTES TO THE FACILITATOR

LEGAL OPTIONS
To get a Protection and/or Occupation Order the woman must prove abuse, fear, and the presence of mental or physical injury. This is not to say that if she cannot prove these three things, that her situation is not dangerous, only that she will have to pursue a course of action that doesn't rely on the judicial system.
If a request for protection is successfully brought against the perpetrator the court

can issue a restraining order, either a Protection Order or/and an Occupation Order, under the 2007 Domestic Violence Act. It is possible to issue both types of orders or to issue either for a longer time-period than the usual 12-month duration if the magistrate deems it necessary for adequate protection. Most restraining orders are personalized to the woman's needs and her particular situation.

If a woman presses charges it will take at least two weeks to reach the Family Court or the Magistrate's Court. In Zimbabwe when does the Magistrate Court turns into a Family Court every week, to hear only the Family Court cases. If the abuse is classified as grievous harm, dangerous harm or maim the case is dealt with as a criminal case and accordingly goes through the Supreme Court, the waiting time for court cases here can be between three and five months. Requests for Orders are only denied in the cases where a woman is harassed due to her approaching the alleged perpetrator (judgment: harassment would not occur without provocation) or when domestic violence is deemed a self-defensive act.

If the abuser is arrested and sentenced on a charge of domestic violence or if he violates his restraining order, he faces up to six months imprisonment or $5,000 Bz maximum fine (or both). If it is a first offense, the abuser will probably be fined rather than imprisoned. In rare cases, the abuser might instead be referred to counseling. This is only used in cases where the abuser is a first-time offender and the level of past and potential harm is judged to have been or to be not very great. However, if a women presses charges it will take at least two weeks to reach the Family Court or the Magistrate's Court. In Cayo district the Magistrate Court turns into a Family Court every Friday, hearings will only be given at the Family Court. In the mean time women are in danger of retaliation from the abuser, particularly if they must continue to live with the abuser. If the abuse is classified as grievous harm, dangerous harm or maim the case is dealt with as a criminal case and accordingly goes through the Supreme Court, the waiting time for court cases here can be between three and five months. Requests for Orders are only denied in the cases where a woman is harassed due to her approaching the alleged perpetrator (judgment: harassment would not occur without provocation) or when domestic violence is deemed a self defensive act.

A Protection Order...
Has the abuser return personal property of the survivor
Has the abuser pay maintenance to a child or dependent
Stops the abuser from:
Being at the home, work-place or neighborhood of the survivor
Being in a certain named place where the survivor goes
Being in a particular area or neighborhood
Speaking to, sending messages, harassing, behaving in an offensive manner towards, or sending messages to the survivor

Orders that the survivor or any child receive counseling
According to the simplified Domestic Violence Act, the Protection Order also grants the survivor the sole right to live in the household residence

An Occupation Order...
Grants the survivor the sole right to live in the household residence
Stops the abuser from living in the household residence
Grants the survivor the use of household furniture, appliances and other household effects e.g. bed, stove, refrigerator, tables, chairs, pots and pans etc.
Where the residence is rented the court can order that the abuser continue to pay rent

Unfortunately, many abusers disobey Protection and Occupation Orders and continue to abuse their partner. Although the police are obliged to provide interim protection until the court date, this is difficult due to a lack of resources. If further incidences of violence are reported to the police then the abuser can be arrested and imprisoned without charge because he is breaking the law under the Protection or Occupation Order. However, women frequently do not report continued abuse because they fear that the police will not respond and that the abuser will only increase the abuse. Additionally, the majority of women are uneducated about the legal system and their rights under the Domestic Violence Act.

If the abuser is arrested and sentenced on a charge of domestic violence or if he violates his restraining order, he faces up to six months imprisonment or $5,000 Bz maximum fine (or both). If it is a first offense, the abuser will probably be fined rather than imprisoned. In rare cases, the abuser might instead be referred to counseling. This is only used in cases where the abuser is a first-time offender and the level of past and potential harm is judged to have been or to be not very great.

PROTECTION & SHELTER

There are several shelters organizations for women in Zimbabwe, but few people may be aware of their existence. The restraining orders are not enough to prevent an abuser from harming a woman if he is intent on doing so. No real protection can be provided without more shelters around the country. Currently it is rare to offer a safe-haven unless wounds are very severe or if past experience implies that continued abuse could be fatal and if the woman is not willing to leave the abusive relationship. In other countries that offer a more comprehensive support system for survivors of domestic violence, the shelter is an integral part of the system. Not only do shelters provide security and protection for women, but they also serve as the basis for all other support services; including outreach, drop-in centers, counseling and telephone help-lines.

When women report domestic violence to the Women's Organisations, the officer there can only log the report and advise them of their options). Consequently, most women are sent back to the abuser if family or friends cannot/ will not help, unless the case is considered to be life threatening in nature, in which case a referral to Musasa Project would be made (the above statistics illustrate the rarity of this). Provisions need to be made for women's protection, particularly in the waiting period between the reporting of a domestic violence case and it's court hearing. The waiting period is two weeks if classified as a domestic violence case, where harm is not dangerous, or between three and five months if classified as a criminal case, where harm is dangerous.

Rural women, in particular, are at risk. Because many men are employed through seasonal farm work, women in domestic violent situations can be trapped at home for long periods of time with their abuser when he is out of work. Further, transportation to and from some villages can be limited, unreliable and sometimes non-existent, for example when roads are flooded during the wet season. Some women can be isolated and will not see a neighbor for days, in which time evidence of abuse will have faded. It is much harder for women from the villages to get away from work at home to go to the nearest town to report gender based violence or domestic violence, and because of the limited service there is no guarantee that the Survivor Friendly Unit police officer in Zimbabwe will be available to log the report or press charges. Most villages are served by one community telephone or none at all, which further hampers the reporting of gender based violence and domestic violence. Simply, there is not the same level of service for rural women as for town women, limited though that may be.

MODULE IV: LEADERSHIP

Materials: Flip Chart, Chalk Board, Markers, Chalk, Pieces of cloth

Objectives (5 minutes)

By the end of the session participants should be able to;

1. Provide leadership training to the communities
2. Explain the meaning of leadership
3. Define a leader
4. Discuss how one becomes a leader
5. Describe qualities of a good leader
6. Explain functions of a leader
7. Describe the leadership styles
8. Explain why confidence building amongst women is important.

ACTIVITY 1: Brainstorming (20 minutes)

Step 1: Ask participants to brainstorm on the meaning of leadership?
Step 2: Ask participants to define a leader.
Step 3: Record the answers given.
Step 4: Ask participants to explain how one becomes a leader.
Step 5: Consolidate the answers.
Step 6: Present additional views and link them to answers provided by Participants
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Activity 2: Group discussion (25 Minutes)

Divide participants into smaller groups to answer the following questions

(a) Who is a leader?
(b) What are the qualities of a leader?
(c) What are the functions of a group leader?
(d) Ask participants to look at the pictures

Activity 3: Plenary discussions (10 Minutes)

Step 1: Ask all participants to report on one question at a time.
Step 2: Consolidate all the answers given.
Step 3: Together with participants isolate the given functions of a leader into maintenance and task functions.

What is leadership?

? Leadership is a process of influencing people towards the achievement of a goal.
? A collection of skills and actions that encourage
- Broad based participation
- Facilitate consensus building
- Distribute shared responsibility

Develop new leaders and enable groups to work effectively to achieve their shared goal

Who is a Leader?

? A leader is a person who guides or directs a group, team or organisation etc.

There are several ways how one may become a leader and some of these are

1. Appointment: Someone in high authority could appoint one of the subjects to be a leader e.g. the president

2. Imposition:One may impose himself or herself to be a leader e.g. by overthrowing a leader of that particular time. However, other people may also impose a leader on the group.

3. Inheritance: This happens within the traditional hierarchy whereby a son or a niece takes over the chieftainship of the father or uncle.

4. Election: This could either be through secret or open voting. This is the most desirable or preferred way of choosing leaders because it is participatory in nature.

5. Influence: A person can also become a leader because of responsibilities, past record of achievement, wealth, family relationships and experience beyond that of other members of a group.

What makes one a leader?

Reward power: Leadership is obtained because followers expect to be rewarded.

Information power: A person with information gets into leadership because of it.

Connection Power: One who is connected to an influential person assumes leadership.

Coercion Power: A person uses force to get to the position of leadership and power.

Qualities of a Good Leader

? Respects and treats others as equals
? Is enthusiastic in achieving group objectives
? Is resourceful
? Has love for other members
? Promotes group ideals
? Motivates group members
? Delegates
? Encourages participation in decision-making
? Has negotiation skills

FUNCTIONS OF A LEADER IN A GROUP

There are several functions of a leader. These can be classified into task and maintenance functions.

Task functions

These are functions that are inclined towards achieving group tasks and how well the group is working together. Some of the task functions of a leader are to;

1. Steer the group towards achieving its main goal
2. Monitor and evaluate progress of group activities
3. Consult and seek information for alternative solutions

Maintenance function

These are functions, which help the group to work as a team and maintain good human relationships. Some of the maintenance functions of a leader are to;

1. Encourage group members to take part in all group activities
2. Help members to relate their ideas properly
3. Observe and control members reactions
4. Make sure that conflicts in the group are dealt with properly
5. Control the level of participation

? A leader develops and achieves the job or task
? Builds up and coordinates a team
? Develops and satisfies individual needs

A good leader aims at balancing the three

LEADERSHIP STYLES

1. Authoritarian/Dictatorial/Autocratic Leadership

The leader makes decisions and imposes them on the people.

Workshop venue

The workshop hall was good and conducive to learning and sharing

The food quality and variety was good

Service and cleanliness of rooms was good

Workshop process

The workshop objectives were relevant to my gender capacity needs and training skills

The workshop provided enough time for questions and discussions

The subject matter was clearly presented and easy to follow

Facilitators created a participatory environment

Workshop content

I can describe some gender concepts and their meaning

I can identify gender issues in the programmes/projects I work with

I can describe how gender links to various HIV/AIDS issues and how they can influence women and men's health

I can develop and manage a leadership skills training

I can facilitate a negotiation

Comments on the workshop

1. **Facilitation**

2. **The use of group work tasks**

3. **Resources and materials**

4. **What else do you need to help you integrate gender in your work?**

5. **What was most helpful?**

6. **General comments**

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Theme: MEN, CULTURE &
Men of quality are not afraid of equality. Real men